

Guidelines for Best Practice  
in  
Child and Adolescent  
Mental Health Services



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Office of Mental Health and Substance Abuse Services  
Bureau of Children's Behavioral Health Services**

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*April 2001 (includes 2007 editorial corrections and revised Life Domain Format)*

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## INTRODUCTION

The documents in *Guidelines for Best Practice in Child and Adolescent Mental Health Services* address many of the clinical challenges that practitioners regularly face, by offering a set of qualitative standards. Developed over time based on cumulative experiences within the children's system of care and consistent with CASSP Principles, the documents address a range of tasks, issues, and topics and are intended to help agencies and practitioners achieve a high quality of care. The overriding assumption is that effective clinical practice facilitates positive outcomes. Protocols and discussion papers can create a useful framework for systematic, conscientious clinical pursuit. Ultimately, however, specific decisions within a service system that values individualization are made on an individualized, clinical basis.

There are three main sections: Assessment, Practice, and Behavioral Health Submissions. Within each of these sections, documents are organized according to specific topics. In what follows, each section will be discussed further.

### **Assessment:**

The Assessment section first addresses psychiatric and psychological evaluations. Although the disciplines of psychiatry and psychology differ in training and expertise in some ways, in Pennsylvania both psychiatrists and psychologists can serve as "prescribers" of community-based behavioral health services. Both can also prescribe non-JCAHO residential treatment facilities (RTFs), but only psychiatrists prescribe for JCAHO RTFs. The evaluation protocol presented applies to both disciplines for use when behavioral health services are being requested. The protocol can be used, as described here, with slight modification, for both initial and continued care requests. It can also be used to request all levels of care, not just Behavioral Health Rehabilitation Services (BHRS) and RTF services. Since the Life Domain Format helps the evaluator obtain comprehensive information about the child that includes but goes beyond presenting behaviors and symptoms of concern, it can be used whether or not BHRS and RTF are being requested (note the 2007 revision of the Life Domain Format).

A useful evaluation cannot be part of an assembly-line process, and instead must be the considered summation of an evaluator's intense contact with a unique child and family at a critical moment in time. A useful evaluation should build on child and family experiences and include thoughtful, individualized recommendation. Therefore, it is appropriate that the key aspects of the evaluation process (interview, written report, and recommendations) are also considered here from an ethical perspective.

The Assessment section also discusses a Strengths-Based Assessment Report. The inclusion of guidelines for a Strengths-Based Assessment Report must not mislead practitioners into believing that the identification of the child and family strengths can be assigned to only one specific individual. Identifying and building upon strengths is the responsibility of every professional and support person who encounters the child and family. Strengths best emerge by listening to the child and family, asking questions, and engaging in unpressured discussion. The Strengths-Based Assessment Report is an additional procedure that can be used to elucidate strengths and competencies, but in no way relieves each of us from doing the same.

Finally, the Assessment section considers two important special topics. Given the importance of comprehensive information when school-based services are used, this issue is addressed ("Documenting the Need for Mental Health Services in the Schools"). Given the public health concern about youth

violence, as assessment tool related to this topic is included (“Child and Adolescent Readiness for Nonviolent Problem-Solving: Assessment Parameters”).

### **Practice:**

“Practice” here refers to all processes other than evaluations and assessments that involve qualitative aspects of treatment interventions with the child and family, collaboration, treatment monitoring, and the use of natural supports. Case-specific efforts at sound practice, as important as they are, cannot sustain our important behavioral health initiative unless accompanied by efforts at all levels to create a positive public sector culture. Each of us is obliged to make this effort, and to enlist the support of others in this endeavor.

It needs to be recognized that most procedures within these documents for sound practice with BHRS apply also to other services, including traditional outpatient treatment. The focus on so-called “wraparound services” emerged in recent years because these were the newest and potentially most flexible services. However, the guidelines in this packet apply to other services and levels of care. It should also be appreciated that the availability of BHRSCA in no way renders traditional outpatient treatment obsolete. Outpatient therapy remains the least intrusive, most normalized, behavioral health service, and should be used when clinically best suited to the child’s needs.

The Practice section also delineates some aspects of strengths-based treatment and discusses the use of natural supports. Other topics include: the clinical interview; methods for achieving collaboration; specific aspects of cultural competence; the interagency team meeting; guidelines for home-based treatment (e.g., BHRSCA and Family-Based Mental Health Services); use of Therapeutic Staff Support (TSS), when medically necessary; use of psychotropic medication; and a self-assessment document to promote the implementation of genuine biopsychosocial treatment.

### **Behavioral Health Submissions:**

Since a funding source typically does not observe actual evaluation and clinical practice, there is reliance on documentation to determine medical necessity for initial care and continued care requests, respectively. We presume that the provider who comprehensively documents need and treatment is offering comprehensive treatment as well. While this is not always the case, the frequent association between documentation and practice should not come as any surprise. For example, comprehensive evaluations, progress notes linked to an individualized treatment plan, and evidence of frequent communication and collaboration, including team meetings convened as clinically indicated, all represent sound work efforts likely to result in positive outcomes and satisfied clients.

The Behavioral Health Submission section includes guidelines for behavioral health submissions to any funding source, and to behavioral health managed care under HealthChoices in Pennsylvania. Here again, although the identified focus may be on “wraparound services,” the suggestions are clinically based and apply to a full range of service requests.

The packet closes with an original “Rap for Pennsylvania CASSP Principles” and Pennsylvania’s formal description of CASSP Principles. Given the centrality of CASSP principles to our children’s system, it is important that these principles be understood by as many stakeholders as possible. This rap, playful yet serious, is intended to offer another vehicle to reinforce these principles, and to promote a positive public sector culture.

**Conclusion:**

The *Guidelines for Best Practice in Child and Adolescent Mental Health Services* is a collection of documents that broadly addresses, through qualitative standards, many of the challenges facing agencies and practitioners in daily work. The scope includes Assessment, Practice, and Behavioral Health Submissions. Although often pitched to BHRS, the guidelines in fact are more generic and apply to the range of services for children and adolescents and their families.

Given the breadth of behavioral health assessment and service provision, these guidelines are not fully inclusive. Choices had to be made. The documents, however, are the end product of a series of issues identified statewide as being important to clinicians, children and families. I hope they will help you in your efforts to support children and families.

Gordon R. Hodas, M.D.  
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Office of Mental Health and Substance Abuse Services  
April 2001

## CHARACTERISTICS OF A POSITIVE PUBLIC SECTOR CULTURE

1. Clear values for system of care.
2. Clear practice expectations.
3. Facilitative regulations.
4. Empowered families and advocates, with participation in policy development.
5. Preparation and dissemination of guidelines for best practice.
6. Emphasis on training and technical assistance.
7. Use of newsletters to communicate new ideas, share experiences, and celebrate success.
8. Presence in every county.
9. Decentralized structures for decision-making.
10. Cross-systems initiatives.
11. Using managed care and welfare as tools for positive systems change.
12. Careers and prestige for public sector clinicians and workers.

# ASSESSMENT

## PARAMETERS OF STRENGTHS-BASED SYSTEMIC ASSESSMENT IN CHILD AND ADOLESCENT MENTAL HEALTH

### **A. Strengths Within System**

1. Strengths of individual child or adolescent
2. Family strengths: individuals, relationships, resources, goals/aspirations
3. Cultural strengths: expectations, rituals, other practices
4. Interagency strengths: resources and relationships
5. Community strengths: resources and relationships

### **B. Possible Needs/Concerns**

1. Economic factors/concrete service needs
2. Racism or other types of discrimination
3. Individual vulnerabilities: child/adolescent, other family member
4. Family vulnerability: fragile relationships
5. Cultural variation
6. Interagency vulnerability: limitations of resources, agency conflict, family-agency conflict

### **C. Desired Outcomes**

1. Active child and family participation during assessment and treatment—treatment planning, implementation, monitoring. Family as full partner in treatment team.
2. Development of respectful, trusting relationships among providers, child and family.
3. Development of consensus within interagency treatment team re: strengths/needs, goals, treatment plan, specific services.
4. Services fully consistent with CASSP principles.

## PSYCHIATRIC/PSYCHOLOGICAL EVALUATION FOR WRAPAROUND OR RESIDENTIAL TREATMENT Discussion of Goals and Format

The *goals* of the **Life Domain Format for Psychiatric/Psychological Evaluations: Initial and Continued Care** are:

- a. To help the evaluator implement a strengths-based interview and written report that identify competencies and resources as well as needs, so that each child and adolescent can be understood biologically, psychologically, and socially (e.g., understood within various life domains), resulting in a comprehensive understanding of the child and family.
- b. To help the evaluator identify crisis situations, and ascertain when a child requires a highly restrictive level of care such as inpatient psychiatric hospitalization or RTF.
- c. To help the evaluator to obtain core information, so that the interagency team is free to promote an envisioning of positive, future outcomes and to develop a creative treatment plan, rather than engage in a recitation of past failures.
- d. To assist the evaluator in recommending individualized services and natural supports consistent with CASSP Principles, which support the child's remaining in the natural family or elsewhere in the community, when possible, or the child's successful return to the community.
- e. To support the inclusion of parents/caregivers and other treatment team members in a portion of the evaluation process.
- f. To encourage participation by the psychiatrist or psychologist as an active member of the interagency and treatment teams, helping to achieve consensus regarding needs and services, and monitoring progress.
- g. To create a comprehensive document that serves as a baseline for future evaluations, and as a source of reference for a subsequent review of the child's progress over time.

This recommended *format* guides the systematic collection of core information about a child or adolescent with a serious emotional disorder, and assists the evaluator in prescribing medically necessary behavioral health services and in making relevant recommendations.

The LIFE DOMAIN DORMAT makes use of seven primary categories or sections: *Identifying Information, Reason for Referral, Relevant Information, Interview, Discussion, Diagnosis, and Recommendations.*

- I. *Identifying Information:* This section immediately places the individual child in the context of the family, community, and treatment team. It is not possible for a reviewer to determine medical necessity for behavioral health services if the child's basic living situation and life context are not identified.

- II. *Reason for Referral:* This is an opportunity to clearly establish the reason for your involvement as evaluator. When there is more than one reason (e.g., the psychiatric prescriber is evaluating for BHRSCA and also monitoring psychotropic medications), this should be clearly identified.
- III. *Relevant Information:* In an effort to promote understanding of the whole child, this section is further divided into the following domains:
- A. *Strengths*
  - B. *Concerns*
  - C. *Family*
  - D. *School*
  - E. *Community*
  - F. *Drug and Alcohol*
  - G. *Services (All human services, including but not limited to behavioral health):*
    - 1. *Services and Service History* (for initial request)
    - 2. *Services and Services Update* (for continued care request)
  - H. *Other (Based on age of the child, presenting concerns, and relevant history)*
- Note: For *continued care requests*, the *Relevant Information* section begins with a section entitled, *Brief Update*. The *Brief Update* section provides an opportunity to highlight key developments during the most recent service period. These changes are further elaborated, under relevant categories, A-H.
- Note: Although there is a discrete section for “Strengths,” it is expected that the recognition of strengths/competencies is reflected throughout the entire report.
- IV. *Interview:* The written summary of a time-specific, face-to-face interview describes the child’s interactions/relationship with you and any other participating adults. It also describes the child’s unique thoughts and wishes, along with other formal mental status categories. It is only by describing a real person that a report can be individualized.
- V. *Discussion:* This section integrates information provided by the child, family, treatment team, interview, and medical record, from a strengths-based perspective, and offers a hypothesis to explain the situation. Begin with the presumption that the child can be maintained in the community. If you recommend RTF placement, justify this in terms of the severity of the disorder, and explain the need for 24-hour treatment. Discuss the rationale for recommended services, and for the diagnosis to be assigned.
- VI. *Diagnosis:* Completion of all five axes is necessary. A “V” code can be used, when appropriate, in Axis I. Specification of psychosocial stressors in Axis IV links the child’s individual needs to the broader psychosocial context. A GAF is necessary for Axis V, offering an estimate of the child’s level of functioning, relevant to the scale.
- VII. *Recommendations:* List and number all recommendations. Include psychotropic medication and other medical issues, when relevant. Identify all interventions, services, and resources of potential benefit to the child and family, not just behavioral health services. Coordinate recommendations with the referral source and the interagency team. When prescribing residential treatment, offer treatment recommendations to the facility, including a tentative discharge plan.

## LIFE DOMAIN FORMAT FOR PSYCHIATRIC/PSYCHOLOGICAL EVALUATIONS: INITIAL AND CONTINUED CARE

**3rd Edition, 2007**

**Note:** This format is applicable to both initial and continued care evaluations. However, when writing an evaluation for continued care, it is recommended that Section III, **Relevant Information**, begin with an additional subheading called *Brief Update* that identifies and briefly summarizes the key events and changes during the most recent service period. The remainder of Relevant Information then follows the usual format (e.g., *Strengths*, *Concerns*, etc.).

### **I. Identifying Information:**

- A. Places the child in individual, family, cultural, residential, and educational/vocational contexts (e.g., age, date of birth, gender, race, ethnicity, cultural/religious beliefs, name and grade in school, type of class setting).
- B. Identifies family and household members, including each biological parent, stepparents, siblings/half-siblings. Identifies marital status of parents, and nature of child's contact with a non-custodial parent. Identifies employment status of current parental caregivers. Identifies custody of the child, and child's legal status (e.g., adjudicated or not).
- C. Identifies other team members, including involved professional agencies/systems (e.g., MH/MR, C&Y, juvenile justice, case management, child psychiatrist, special education, etc.) and community supports.

### **II. Reason for Referral:**

- A. Identify if evaluation is for initial care or continued care.
- B. Identify any specific questions and concerns giving rise to evaluation request.
- C. Identify sources of information.

### **III. Relevant Information** (begin with *Brief Update*, if a continued care request):

- A. *Strengths:*
  - Child/adolescent strengths, in multiple domains.
  - Special attention to motivation, plus ability to form relationships and use support.
  - Areas of greatest interest, competence, and independence.
  - Evidence of resilience.
  - Family and community strengths.
- B. *Concerns:*
  - Clinical basis for current service request and recommended treatment.
  - Nature, frequency, severity, and history of the child's behaviors/symptoms/serious emotional disturbance (SED) of concern.
  - Identification of both externalized behaviors and internalized symptoms, comparing present to past. High-risk behaviors.
  - Progression of concerns over time.

- Other identified needs and concerns.
- C. *Family:*
  - Family composition (including relevant extended family), family relationships, strengths/concerns.
  - For child in substitute care, foster family and natural family included.
  - Family cultural and spiritual beliefs and practices, as relevant.
  - Family history of psychiatric disorder and treatment.
- D. *School/Vocational:*
  - Prior school adaptation and placements.
  - Characteristics of current school and specific class setting.
  - Current academic, social, and behavioral adaptations, including relationships with school peers and with teachers and/or level of functioning in vocational programming.
  - Efforts to date of school to address current problems.
  - Current or past use of school-based services.
  - Results of prior or recent functional behavioral assessment, if completed.
  - Results of current or past educational or IQ testing, CER, and IEP.
  - Transition planning, for adolescents.
- E. *Community:*
  - Place of residence—family home or apartment, group home, RTF, etc.
  - Community activities and attachments.
  - Use of leisure time.
  - Community employment, current and in past.
  - Degree of church or spiritual involvement.
  - Nature of neighborhood, in terms of resources and culture, safety, specific conditions.
  - Specific stressors, as relevant.
- F. *Peer Relationships:*
  - Patterns of peer relationships in the neighborhood and in school, including similarities and differences between the two settings.
  - Predominant age of peers—same-aged, older, or younger—and gender of relationships.
  - Predominant activities with peers, formal and informal. Nature of peer culture.
- G. *Drug and Alcohol:*
  - Child's current use/abuse of drugs & alcohol—type, frequency, severity. Cigarettes.
  - Huffing or other dangerous substance use.
  - Child's past history of substance use, and impact on functioning.
  - Extent to which child views substance use as a concern.
  - Child's past drug and alcohol treatment, response to treatment, involvement in self-help groups.
  - Family substance abuse history, where relevant, including nature of use, type and effectiveness of treatment.

- H. *Medical/Developmental:*
- Pregnancy, including medical or psychological complications, maternal smoking, and maternal drug or alcohol use. Prenatal care.
  - Delivery, including any complications and neonatal distress.
  - Neonatal period.
  - Developmental milestones – motor, speech and language, cognitive, emotional, adaptive. Relational capacity.
  - Lead or other toxicity.
  - Specific sensory idiosyncrasies. Stereotypical movements.
  - Mental retardation, atypical development, autism/PDD.
  - Medical illness, acute or chronic infection, physical limitation, serious accident or injury, sensory limitation, past surgery.
  - Neurological disorder: seizures, loss of consciousness, traumatic brain injury.
  - Medications for physical health or neurological disorders.
  - Medication for allergies.
  - Past pregnancy, for females.
  - Gender preference and gender identity, when relevant and with consent of the child, and other issues of sexuality.
- I. *Trauma History:*
- Physical abuse.
  - Sexual abuse.
  - Psychological abuse.
  - Neglect.
  - Witnessing of domestic violence or other violence.
  - Traumatic loss.
  - Multiple separations from primary caregivers.
  - Victimization in community – bullying, sexual molestation or rape.
  - Trauma in institutional care, including traumatic restraint experiences.
  - Medical trauma.
  - Other – refugee trauma, natural disaster, war, terrorism, etc.
- J. *Legal:*
- Custody – with biological parents, other relatives, Child Welfare, adoptive parents, or emancipated youth..
  - Adjudication as delinquent or dependent.
  - Prior arrests.
  - Other delinquent status indicators: probation, placement in juvenile facility, incarceration.
  - Outstanding legal issues: pending charges, community service requirement, other.
- K. *Services:*
- Service History:
- Services used in past, reason, level of participation, and effectiveness. Include all mental health services and levels of care, out-of-home placements (mental health and other), and services from other systems.
  - Prior mental health diagnosis. Past psychiatric or psychological evaluations.

- Psychotropic medication history – rationale for each, duration, degree of effectiveness, medication adherence, significant side effects.

Service Update:

- Current services—including hours and locations—with summary of recent service history.
- Impact of services:
  - Role of service providers and of family.
  - Progress/degree of attainment of treatment goals and objectives. Identify effective and ineffective interventions.
  - Receptivity of the child and family to services, and level of participation.
- Nature of planned modifications of goals and services.
- Specific indications for, and use of, psychotropic medication. Include names and dosages and, where applicable, blood levels. Indicate medication adherence and effectiveness of medication, when in use.
- Nature of regular clinical updates to prescriber by involved mental health staff, during most recent service period.

K. *Other:*

- Other domains as relevant, or added to earlier information.

**IV. Interview:**

- A. Identification of participants.
- B. The child/adolescent's appearance, hygiene, self-care.
- C. The child/adolescent's manner of relating to the interviewer and other identified adults present. Emphasis on level of engagement, cooperation, and openness to input.
- D. The child/adolescent's formal mental status, including reality testing and suicidality. Identify child's goals, needs, requests, response & commitment to treatment, hopefulness, degree of understanding & insight, other individualized ideas, and ability to contract for safety, when relevant. Compare with previous contacts, when applicable.
- E. Key issues/themes addressed, and areas of agreement/consensus.

**V. Discussion:**

- A. Overview/summary.
- B. Hypothesis/formulation: What appears to be the basis for child's symptoms/behaviors?
- C. Diagnostic considerations.
- D. Rationale for recommended services and interventions.
- E. Nature of consensus and agreements with the child/adolescent, family if present, and others.
- F. Prognosis.

**VI. Diagnosis:** 5-Axis diagnosis.

**VII. Recommendations:**

- A. Response to specific questions and concerns that gave rise to evaluation request.
- B. Identification of each specific behavioral health service recommended, listing the amount, duration, and scope of each.

- C. Recommendations to guide treatment (e.g., interventions for team to consider; other or alternative services; psychotropic medication referral or recommendation; additional assessment(s); community referral(s); education and/or vocational recommendations; consultation with primary care physician; other).
- D. Use and expansion of natural supports.
- E. Recommended criteria for service tapering, termination, or modification of level of care.

## TWELVE TREATMENT ISSUES TO CONSIDER *PRIOR TO* THINKING ABOUT SPECIFIC SERVICES

1. Individual, family and system strengths and supports
2. Child and family experiences and perspective of need
3. Life domains in need of greatest attention
4. Primary target behaviors and symptoms
5. Envisioned, age-appropriate long-term outcomes
6. Realistic, observable outcomes (goals and objectives)
7. Identification of specific barriers to progress
8. Explanation/hypothesis regarding maintenance of current problem
9. Prior intervention efforts
10. Completeness of representation within interagency team
11. Level of commitment of team members to address problem and to work together
12. Unique cultural or other dimensions for incorporation in treatment

## FORMULATING THE PRESCRIPTION/SERVICE SELECTION: GUIDING QUESTIONS FOR THE PRESCRIBER

### 1. *Adequacy of Information:*

- Have I obtained and incorporated information from the referral source and/or team?
- Have I read available records?
- Does my information form the basis of a comprehensive report?

### 2. *Clarity of Clinical Understanding:*

- Do I have an understanding of what is going on?
- Have I considered the clinical situation from a full biopsychosocial perspective?
- Do I understand the desired, envisioned outcome of the child and family?
- Do I have a hypothesis to explain why the child is struggling (and why treatment is stalemated, if applicable)?

### 3. *Natural Supports and Family Participation:*

- Have I identified natural resources/natural supports for the child, as the foundation upon which professional services can build?
- How can I best support the participation of the child's parents/guardian, and other available family members?
- As treatment progresses, is the use of natural supports increasing?

### 4. *Level of Care and Specific Service Selection:*

- Have I recommended the most appropriate level of care for the child, given degree of need and the available resources and supports—e.g., least restrictive/least intrusive?
- Is my service selection consistent with the hypothesis regarding the nature of the problem and how it is best addressed?
- Am I bundling services unnecessarily, or is there a necessary and distinct function for each service that I recommend?
- Are the intended settings for each service clear?

### 5. *Service Intensity:*

- Is the recommended intensity for each service consistent with the intended role of that service?
- Does each requested hour of requested service make a clinical difference for the child—e.g., why is this intensity appropriate, rather than one hour less, or one hour more?

- Does the recommended intensity of services allow leisure time for the child and an opportunity for normalized living and independent problem-solving for the child and family?

6. *Additional Individualized Recommendations, to Promote Quality Treatment*

- Have I offered additional recommendations, as appropriate, to strengthen the treatment process, or are my recommendations limited to prescribing services in need of approval?
- Based on what I have learned, what are my recommendations regarding: treatment strategies and next steps; referrals; natural supports; service integration, psychotropic medication; service tampering; other ideas for service providers?

## CHARACTERISTICS OF A QUALITY EVALUATION REPORT

1. *Comprehensive:* Report provides necessary identifying information about the child and family, discusses the child within multiple life domains, and addresses issues of clinical relevance. Report is a stand-alone document that does not presume reader's prior knowledge of the child or the review of an earlier evaluation report.
2. *Organized:* Report follows a protocol with designated categories and sub-categories of information, rather than being one continuous narrative. Within each category, information presented is relevant to subject or issue. Information flows, creating a cohesive story. Use of the Life Domain Format for Psychiatric/Psychological Evaluations, as presented in this packet, is strongly recommended.
3. *Respectful:* Report identifies the child and family members by name, avoiding inappropriate designations such as "Mom" or "Dad." Concerns are described in non-judgmental manner, without use of pejorative terms (e.g., "dysfunctional," "alcoholic," etc.). Strengths and goals, not just problems, are identified. Language reflects evaluator's appreciation that the report is a public document that will influence current and future attitudes.
4. *Individualized:* A unique child emerges, through the scope of information provided within the entire report and through the evaluator's description of the child's manner of relating and functioning during the clinical interview. Rather than relying solely on patient responses to formal mental status parameters (e.g., insight is "good," "poor," or "fair"), the report identifies the child's specific thoughts, ideas, and responses, thereby offering a glimpse of the child's actual experiences, developmental progression, and degree of insight.
5. *Thoughtful:* Evaluator is catalyst for quality and integration, especially through "Discussion" and "Recommendations" categories of the written report. Recommendations go beyond the prescription of only medically necessary services for funding—e.g., recommendations offer direction to the child and family and to direct care staff working with the child and family, and help link the child and family to appropriate services and resources.

## SELECTED ETHICAL ISSUES FOR ANY EVALUATOR AND FOR THE BHRSCA PRESCRIBER

1. *Requesting and reviewing available documents:* To ensure that all information does not come solely from the child, and that the evaluation is guided by externally verified data.
2. *Talking with referral sources:* Same as above, and to obtain clear focus as to the reason for referral.
3. *Inviting family participation in interview:* To convey importance of family participation, even in evaluations, and to broaden base of information.
4. *Making a real connection:* to create a sense of “welcome and to convey to the child and family that they matter to you and are not just “another case.”
5. *Requesting and listening to the story:* So that you can become immersed in, and come to understand, the situation as experienced by the child and family.
6. *Asking for suggestions from the child and family:* To obtain the client perspective of what is needed, which is invaluable in treatment planning.
7. *Offering constructive feedback:* To highlight strengths not just needs, and to offer suggestions and a sense of continuity to the child and family, in moving to the next steps.
8. *Assigning an accurate diagnosis:* To ensure that the diagnosis is consistent with best clinical judgment, not selected for non-clinical reasons.
9. *Describing the child and family respectfully:* To recognize the need for respectful documents, and the impact of the written report on others.
10. *Providing a balanced description of the child:* To include strengths, and describe needs accurately. It is not appropriate to overstate needs/disability, in order to obtain additional services.
11. *Requesting services consistent with current need:* To ensure that the requested level of care, service selection, and service intensity all reflect the child’s actual needs. The team can request more, if unexpected developments occur. Inflating a request, whether in anticipation of a partial denial or to obtain a buffer, is inappropriate. Address current needs without promoting unnecessary service dependency.
12. *Offering recommendations beyond just billable services:* To use your broadly based clinical experience to offer additional ideas that promote comprehensive treatment.
13. *Collaborating with the interagency team:* To demonstrate that you are part of the team. Be open to additional information, and consider the interagency team meeting recommendations, if different from your own. Ultimately, follow your best clinical judgment.

14. *Operating in a manner consistent with professional scope of practice and with professional code of ethics:* To recognize that the professional code of ethics and defined scope of practice provide the first set of ethical standards for the evaluator or prescriber.
  
15. *Operating in a manner consistent with CASSP Principles:* To recognize that in Pennsylvania, CASSP Principles provide a second ethical standard for the evaluator or prescriber.

## PROTOCOL FOR A STRENGTHS-BASED ASSESSMENT REPORT

### **Rationale:**

Effective mental health treatment for children and adolescents and their families depends in part on the identification and support of individual and family strengths. Yet there often is limited information about strengths within evaluations and treatment plans, and during interagency and treatment team discussion. This Protocol for a Strengths-Based Assessment Report can help the mental health team more fully recognize individual and family competencies and strengths.

### **Treatment Contexts for Use:**

This Protocol can be used in outpatient, partial and inpatient settings, and as part of home/community services and other EPSDT mental health services. Home/community services offer an ideal opportunity to pursue a strengths-based assessment.

### **Who Completes the Strengths-Based Assessment Report?**

Any involved clinician or case manager can complete the written Protocol for a Strengths-Based Assessment by talking with the child individually and with the parents or other adults in a family interview. Siblings can be included during the family interview. Information can also be gathered at different times and then written up. The treatment team should designate one person to complete the assessment report. With home/community services, this individual can be a mobile therapist, behavior specialist consultant, outpatient therapist or case manager.

### **At What Point in Treatment Should the Strengths-Based Assessment Report Be Completed?**

Mental Health treatment should be strengths-based from the moment of first contact with the child and family. A discussion of strengths should be included in every psychiatric or psychological evaluation, treatment plan and case management summary. Since obtaining all of the information contained in this protocol requires time and a trusting relationship with the child and family, the Strengths-Based Assessment Report may need to be completed after initial contact, as treatment unfolds. The Strengths-Based Assessment should be completed and written up as soon as possible, in order to help guide the direction of treatment.

### **Does Completion of the Protocol for a Strengths-Based Assessment Report Assure that Treatment Will Be Strengths-Based?**

In addition to the specific information obtained, it is important that the child and family encounter a curious respectful interviewer. The information obtained through this protocol can help the team discover important aspects of the child and family that may have been previously unknown or undervalued, enabling treatment to proceed in a constructive, empowering way. For treatment to be strengths-based, there must be an unwavering commitment on the part of the team to approach treatment in this manner.

## PROTOCOL

### A. Child

1. Interests, skills, activities and competencies
2. Most significant/most valued accomplishment (past or current)
3. Strengths as an individual
4. Ways of relaxing and having fun
5. Ways of calming self down when upset or angry
6. Closest adults within immediate family, and reasons
7. Closest adults outside of immediate family, and reasons
8. Closest friends own age, and reasons
9. Clubs or organizations joined
10. Goals for one year from now; five years from now
11. Goals for when a 25-year-old adult
12. Other

### B. Family

1. Jobs, interests and competencies of individual family members
2. Most significant/most valued accomplishments of family (past or current)
3. Strengths as a family
4. Ways of relaxing and having fun as a family (including common interests and activities)
5. Ways of calming family down when upset or angry
6. Closest supports within family
7. Closest supports outside of immediate family
8. Membership in church/synagogue and community organizations
9. Goals for child and family one year from now; five years from now
10. Goals for child when age 25 years
11. Other

## THE NECESSITY OF STRENGTHS-BASED TREATMENT PLANNING WITHIN MANAGED CARE

### **Introduction:**

A commonly voiced concern, particularly with regard to managed behavioral health care, is that service approvals become unlikely if the child's strengths are identified. In fact, it may be argued, prescriber and team need to exaggerate the child's problems and impairments, in order to obtain services. After all, the reasoning goes, the better off the child, the less reason for "managed care" to approve services. This article is intended to offer a quite different perspective on assessment and the approval process—namely, that needs and strengths are complementary, and that the identification of each is essential for cost-effective treatment.

### **Behavioral Health Care Under HealthChoices: We Are Us:**

Public sector behavioral health care under HealthChoices in Pennsylvania represents a hybrid system quite different from typical commercial managed care. Counties have the right of first opportunity, and as of 1999, all but one county of 15 counties currently under mandatory managed care have successfully chosen this option. Even where commercial companies are involved, DPW contracts remain with the county, not the behavioral health managed care organization (the BH-MCO). In addition, many of the decision-makers within BH-MCOs are individuals familiar with public sector values, achievements, and limitations. As a result, there is considerable continuity within Pennsylvania as the shift to mandatory managed care occurs. Stakeholders remain the same, and the contracts mandate the continued participation of stakeholders in the new system of care. While the new system is still evolving and cannot be regarded as perfect, it is not unreasonable to say that, as regards public sector behavioral health in Pennsylvania, "We are us"—i.e., responsibility remains substantially under the purview of the stakeholders, and the system will reflect our values and our efforts.

Beyond these structural considerations, as well as ethical ones that become apparent upon reflection, there are other reasons to conclude that the shift to managed care does not require the abandonment of clinical integrity, in order to obtain services. It must be recognized that every individual has both strengths and needs/areas of vulnerability. There is no person, however competent, who does not have needs and vulnerabilities. Similarly, there is no person, irrespective of limitations, who does not also have strengths. A meaningful behavioral health approach to individuals in need of assistance involves identifying and recognizing both strengths and needs. Only in this way can treatment be truly individualized, with meaningful and enduring outcomes more likely.

Strengths are not theoretical and disembodied from treatment, but in fact serve as the basis for change. Individuals cannot overcome problems by accepting, or merely recognizing, their limitations. An individual's decision to change him or herself reflects an important strength. Indeed, without such an internally derived decision, services become irrelevant and providers are viewed by the individual as nothing more than intruders.

A public sector BH-MCO seeks to utilize services in a well-planned, cost-effective manner and therefore welcomes information about an individual's strengths. Information about strengths serves to increase the likelihood of successfully planned interventions. Without information about such elements as motivation and other attributes, personal goals, past successes, capabilities, community attachments and

natural supports—the BH-MCO faces the prospect of deploying services into what could be regarded as an uncertain, empty hole.

The idea is that an individual can be in legitimate need of professional services and at the same time possess many strengths. More precisely, a person in need of professional services always possesses strengths, and good practice requires the recognition of both needs and strengths, in service approvals and in the actual treatment process. In general, the rationale for most services tends to be based on immediate circumstances, even if the antecedents are longer-standing, while strengths tend to be more enduring characteristics that are less circumstantial. As such, strengths are potentially available for strategic incorporation into treatment. A brief case example may serve to further illustrate these points.

### **Case Example:**

*Mary, a bright attractive Caucasian adolescent, is well-liked by her teachers and has many friends. Mary tends to avoid negative peer influences, attends school regularly, and does her homework. She has never been arrested, and in fact takes an active interest in working with younger kids. When not upset, Mary could be described as “level-headed” and sensible. In fact, Mary was not even receiving mental health services at the time of the contact to be described, although she had been in need of support for some time.*

*At the time of her professional mental health contact, this same individual with many strengths was acutely suicidal, and Mary ultimately required an acute care psychiatric admission later that same day. Mary disclosed to her school counselor that she had jumped off a roof the previous day, somehow avoiding serious medical injuries. She confessed that she still wanted to die. Such thoughts, Mary explained, had been present for some time intermittently, more intensely for the past two weeks. Mary also indicated that recently, she had begun smoking marijuana and using alcohol. This had not occurred in the past, and Mary explained that these substances calmed her down and eased her inner distress to some degree. Following some initial hesitation, Mary went on to tell her counselor about serious instability in her environment and a sense of loneliness that she had been facing, both of which had recently worsened.*

*Initially, Mary insisted that she would be better off dead. Then she proposed running away as the best solution. With further support and discussion, however, Mary acknowledged a desire to face her situation and get help, so that she could feel less distressed and once again value her life. She agreed to a voluntary emergency assessment for hospitalization. The BH-MCO and the family were contacted and Mary was accompanied by the counselor to the nearest affiliated emergency facility. After emergency assessment, Mary was approved for voluntary admission to the hospital.*

### **Case Discussion:**

Given the story as presented, it is clear that, under the circumstances, Mary required an acute admission to a psychiatric hospital. She had made a serious suicide attempt less than 24 hours earlier and was still suicidal. Mary’s depression and hopelessness were apparent. She had further compromised her functioning by abusing substances, and her only perceived alternatives at the time of assessment were self-destructiveness or running away.

While Mary’s need for services was firmly established, the BH-MCO was also made aware of, and benefited from knowing Mary’s many strengths. A partial list indicates that Mary is:

- intelligent;
- attractive;
- caring;
- conscientious about school;
- loyal toward friends;
- level-headed when not in distress;
- usually able to verbalize her needs;
- able to trust adults when help is offered;
- able to make a good choice that offered immediate safety and ongoing support.

Both a therapist (in this case, the school counselor) and a BH-MCO welcome information about Mary's capabilities and coping, because these elements increase the likelihood of a successful outcome. Mary's strengths become the foundation for her treatment, not the basis for a service denial. Her need for service is not at issue. With information about Mary's strengths at hand, the treatment team can move forward constructively and efficiently. For example, the treatment plan can build on Mary's strengths by promoting her expressiveness, along with her capacity to trust, to think, and to accept support. In addition, her environment will need to be better understood in terms of both strengths and current instability, so that family and community resources can be mobilized.

### **Conclusion:**

A prescriber needs to "tell it like it is," and similar considerations apply to the treatment team as a whole. A child's genuine needs, based on emotional and behavioral instability, require realistic provision of services. Such needs should be identified in plain, descriptive language, neither exaggerated nor understated. Use of clinical examples and relevant history in a written report, not just broad generalizations, helps to effectively convey the child's needs. At the same time, an individual's *strengths*—as well as those of the family and community—must also be assessed and identified. To the extent that natural supports can effectively address some of the child's identified needs, the team succeeds in preserving and enhancing self-sufficiency. However, typically there remains a clear need for professional behavioral health services also. When there is clarity in a report about specific needs, the identification of strengths should not undermine a legitimate service request. On the contrary, identification of the child's strengths serves to constructively orient the clinical team and funding source to the next steps. Use of strengths in conjunction with medically necessary services guides the treatment process forward, helping to transform services from a line item into a meaningful, cost-effective vehicle for change.

## QUESTIONS TO GUIDE HUMAN SERVICE RESPONSES TO CHILDREN OR ADOLESCENTS WITH SERIOUS MENTAL HEALTH PROBLEMS

### A. Determining specific services via an interagency service planning meeting:

1. Are representatives of all relevant agencies and systems invited and present for a face-to-face interagency service planning meeting?
2. If the prescribing psychiatrist or psychologist is not present, is there a plan to *coordinate* results of the interagency service planning meeting and the psychiatric/psychological evaluation?
3. Are the specific needs and strengths of the child and family understood?
4. Are the child and family participating actively during the meeting?
5. Have basic mental health services already been initiated--e.g., individual and family therapy, with family participation in developing and implementing user-friendly, culturally competent services?
6. Have community resources been explored and used?
7. Is there a presumption in favor of using the least restrictive services and of maintaining the child in the community, if possible?
8. Do proposed service responses *match* medically necessary needs by addressing specific needs of the child in the most *relevant* domain(s) (e.g., if the child is defiant at home, are services being provided to assist the family with the child?)?
9. If less restrictive services have not been implemented, should such service precede the use of more intensive, restrictive services, or does a crisis require immediate use of more intensive, restrictive services? Examples:
  - a. Trial of ongoing family therapy vs. immediate use of in-home intensive staff support services;
  - b. Use of community recreation vs. intensive after-school services or partial hospitalization program;
  - c. Initiation of MDT and/or psychological testing with change in the child's IEP vs. immediate use of in-school intensive staff support services;

- d. Evaluation for possible use of psychotropic medication vs. immediate psychiatric hospitalization or RTF placement;
  - e. Use of specific mental health settings (e.g., intensive after-school services, therapeutic day camp, etc.) with existing program staff vs. concurrent request for on-site therapeutic staff support.
10. Does the treatment plan *link* the proposed services with the child's specific needs?
  11. Does the treatment plan identify the specific responsibilities of the child as an active agent of change? Are the responsibilities of other important parties delineated?
  12. If other services are needed by the child or family, are appropriate resources identified and appropriate referrals initiated?
  13. Has the interagency service planning team developed a plan for effective *integration* of various services, including lines of professional communication and supervision, and the role of the team including the family in ongoing monitoring?
  14. When the interagency service planning team meets to determine possible re-authorization of services, have *outcomes* during the current service period been reviewed, including the nature of specific interventions/services provided and responses by the child and family?

**B. Psychiatric or Psychological Interview:**

1. Have essential records been reviewed?
2. Is there a plan to *coordinate* the psychiatric/psychological interview and evaluation with the results of the interagency service planning process?
3. Are treatment team members, including family members, invited to participate in the psychiatric/psychological interview?
4. Do efforts at relationship-building with the child and family precede inquiry about problems?
5. Are child and family strengths asked about and noted?
6. Are the child and family given an opportunity to describe the problem in their own words and to suggest some treatment approaches and solutions?
7. Is a clear definition of the problem, and of medical necessity, obtained?
8. Are past treatment efforts asked about and understood?

9. Is the physical safety of the child assured?
10. Do treatment discussions focus on the least restrictive services which address specific medical necessity as previously identified?
11. Has a consensus been achieved, with clarity?
12. Do all participants understand their respective responsibilities in implementing the plan?

**C. Psychiatric or Psychological Evaluation Report:**

1. Has basic identifying information about the child, including but not limited to current family and living situation, been described?
2. Have the specific manifestations of the child's mental illness and/or severe emotional disturbance, which constitute medical necessity, been clearly identified?
3. Have the child and family strengths been identified?
4. Have essential aspects of the child's past history been identified?
5. Have specific recommendations been justified in terms of the child's previously described medical necessity? Do recommended services meet the child's needs in the most relevant domain(s), in the least restrictive manner?
6. For re-authorization requests, does the report describe the **outcomes**, in terms of the nature of specific services provided and responses by the child and family, during the current service period?
7. Does the report follow the recommended life domain format for psychiatric and psychological evaluations?
8. Does the report distinguish carefully between allegations and documented fact?
9. Is the report written in language that respects the struggles of the child and family and that avoids unnecessary use of jargon?

## DOCUMENTING THE NEED FOR MENTAL HEALTH SERVICES IN THE SCHOOLS

*The following categories of inquiry are intended to assist interagency and school-based teams in understanding the child's school-related needs and in fostering a systematic, integrated mental health-education-family partnership that identifies goals, objectives and medically necessary services, within a psychiatric or psychological evaluation and a school-related treatment plan.*

1. Current areas of school-related concerns
  - a. Global functioning
  - b. Functioning within specific school domains (e.g., formal classroom vs. hallway or recess functioning vs. bus behavior, etc.)
  - c. Duration and history of current concerns
2. Efforts at remediation and support to date (identify which are relevant)
  - a. Specific classroom strategies
  - b. Teacher-parent conferences to date
  - c. Other parent participation or efforts
  - d. Prior educational or psychological evaluations
  - e. Prior use of Instructional Support Team or Student Assistance Program staff
  - f. Use of IEP, and nature of Behavior Support Plan within.
  - g. Nature of Transition Plan, for an adolescent.
  - h. Use of tutoring, if indicated
  - i. Use of special education supports within regular classroom setting
  - j. Use of special education setting, if necessary
  - k. Use of psychotropic medication to date, if indicated for specific diagnosis (e.g., ADHD, depression, etc.)
3. Nature of hypothesis to explain the child's related school problems, and envisioned outcome of the child and family, as related to school functioning.

4. Relevant school-related domains for mental health services to address (as identified within the evaluation, and addressed via goals and objectives within the individualized treatment plan):
  - a. Classroom behavior.
  - b. Peer relationships.
  - c. Use of less structured school time (non-academic subjects, homeroom, cafeteria, recess, etc.)
  - d. Bus behavior
  - e. Work habits and academic follow-through.
  - f. Anger controls or impulse management.
  - g. Integration of school and home behavior.
  - h. Promotion of extra-curricular activities and normalized community functioning.
5. Identification of specific, medically necessary mental health service(s), with proposed functions
5. Nature of ongoing collaboration, review and quality monitoring by the treatment team—school staff, mental health staff and the family

## CHILD AND ADOLESCENT READINESS FOR NONVIOLENT PROBLEM-SOLVING/ASSESSMENT PARAMETERS

### A. Individual factors:

1. Anger and rage. Countered by strengths; capacity to connect; ability to think and problem solve.

*Do strengths-based assessment.*

*Ask what are greatest sources of anger and frustration.*

*Review academic capabilities and profile.*

2. Capacity to envision non-violence.

*Ask about experiences in non-violent conflict resolution.*

*Ask about role models who have dealt with conflict non-violently.*

*Ask how role models acted to achieve peaceful resolution.*

3. Social acceptability of non-violence.

*Ask about concept of “being a man” or “standing up for yourself.”*

*Ask about favorite actors, movies, songs, rappers, leaders, etc.*

4. Personal desirability of non-violence.

*Ask if anyone close has been victimized by violence.*

*Ask if child/adolescent has been personally victimized (violence history).*

*Ask how he/she would “like it to be” between people.*

5. Use of drugs and alcohol.

*Ask about attitudes towards drugs and alcohol.*

*Take drug and alcohol history.*

6. Developmental level.

*Determine extent to which the child functions in a manner consistent with chronological age.*

*Determine nature of the child’s conception of death—reversible or irreversible?*

*Assess the child’s capacity to express self clearly.*

7. Availability of weapons.

*Ask about types of weapons available within peer group.*

*Ask about weapons owned by the child or adolescent.  
Ask about weapons in the home.*

8. Possible psychiatric disturbance.

*Observe the individual carefully, noting coherence of speech and overall demeanor.  
Screen indirectly and directly for hallucinations, delusions, clinical depression, etc.  
Determine intactness of reality testing—e.g., ability to distinguish reality from fantasy.  
Determine preoccupation with violence/violent themes in verbalizations and in play.  
Refer for more complete mental health assessment when indicated.*

9. Specific social and problem solving skills development

*Observe the child or adolescent: in classroom, with peers, in community.  
Observe the child or adolescent with adults  
Observe the child or adolescent directly with you.*

10. Degree of personal commitment to pursue nonviolence.

*Ask if the child is prepared to make a commitment to solve problems without violence.  
Ask if the child will participate in proposed program.  
Ask the child to describe the most effective coping mechanisms to date.  
Ask the child to recommend the nature of adult constructive feedback (e.g., best ways for adult to interrupt cycle; what adult should avoid doing).*

**B. Contextual factors:**

1. Family support and participation.

*Determine family strengths.  
Recruit family participation.  
Determine family attitudes about non-violent conflict resolution.*

2. Nature of peer association.

*Determine type of peers with the child associates.  
Determine extent to which the child's behavior differs when alone, and when in peer group.*

3. Nature of neighborhood.

*Determine level of safety, violence, weapons, drug use and drug dealing, etc.  
Determine safe havens and resource persons for the child in the neighborhood.  
Determine most effective way to avoid escalation of conflict in that sub-culture.*

4. Recreational outlets and other community (natural) supports.

*Determine church affiliation.  
Determine after-school and weekend resources—YMCA, clubs, and sports, etc.  
Ask about potential role of extended family.*

5. Nature of media exposure.

*Determine extent to which the child plays violent video games.  
Determine predominant nature of the child's toys.  
Determine extent to which the child views violent movies and violent TV shows.  
Determine musical preferences, including degree of interest in "gangsta rap."*

6. Recent current events

*Determine the degree to which the child follows current events.  
Consider the degree to which recent national events (especially youth violence)  
might have affected the child.*

## PARAMETERS FOR REASSESSMENT OF STALEMATED OR UNSUCCESSFUL TREATMENT

### **A. Assumption:**

When mental health treatment of the child or adolescent is stalemated or unsuccessful, the primary agency and team need to reassess and discuss the possible reasons, not just request/provide the same or additional services. They need to develop and identify modifications in the treatment approach and to provide rationale and justification for the continuation or initiation of services.

### **B. Specific Parameters for Reassessment**

1. Level of engagement of the child
2. Level of family participation
3. Recognition and use of competencies
4. Adequacy of, or need for provision of, psychotropic medication
5. Use of intrinsic (non-professional, community-based), not just extrinsic (formal, professional) supports
6. Adequacy of information base: child, family, community, medication, past history, etc.
7. Adequacy of treatment formulation: need to develop or modify
8. Adequacy of the treatment plan:
  - a. Specificity of goals/objectives
  - b. Accountability of the child and others
  - c. Inclusiveness of domains (not just mental health)
  - d. Feasibility of goals/objectives as currently defined
  - e. Appropriateness/feasibility of desired level of care
  - f. Criteria for tapering of services
  - g. Discharge criteria
9. Adequacy of current diagnosis
  - a. Indications for changing primary diagnosis

- b. Indications for changing secondary diagnosis
  - c. Indications for adding new diagnosis
10. Level of collaboration/consistency/integration:
- a. Within primary agency
  - b. Among agencies and within overall team
  - c. Adequacy of supervision
  - d. Adequacy of communication
  - e. Possible covert or overt disagreements
11. Team meetings (treatment team meetings and interagency meetings):
- a. Regularity
  - b. Flexibility of scheduling, when needed
  - c. Adequacy of system representation
  - d. Adequacy of participation/voice
  - e. Adequacy of implementation/follow-through
12. Educational setting
- a. Adequacy of current class setting and placement
  - b. Indications for specialized services
  - c. Indications for requesting Multidisciplinary Team (MDT) and Multidisciplinary Evaluation
  - d. Indications for convening/reconvening IEP
  - e. Other
13. Use of consultation:
- a. Psychological Testing -- Cognitive and/or projective
  - b. Medication evaluation
  - c. Specific medical evaluation
  - d. Mental health consultation: “fresh look” by individual not currently involved

- e. Other -- speech and language, hearing, academic levels, etc.
14. Cultural barriers:
- a. Individual practitioners
  - b. Agency as whole
  - c. Need for additional knowledge/information
  - d. Language problems
15. Service delivery:
- a. Service selection.
    - 1. Misallocation of services: Problem area/domain not targeted
    - 2. Menu-driven selection: Not individualized choices
    - 3. Critical service not present
  - b. Duration:
    - 1. Time period too short (services just initiated, or delay in initiation)
    - 2. Time period too long (services no longer novel or effective due to prolonged use)
  - c. Intensity:
    - 1. Greater quantity of specific service needed
    - 2. Over-prescription/over-utilization of specific service or overall services
  - d. Method of implementation:
    - 1. Level of competence/skill of staff
    - 2. Level of respectfulness/professionalism of staff
    - 3. Level of reliability of staff
    - 4. Degree of facilitation of caretaker competence by staff vs. rescue of child
    - 5. Counter-transference issues involving staff
  - e. Consumer over-dependency:
    - 1. Services per se

2. Specific staff

**C. Discussion as Part of Submitted Documentation -- Issues to Address:**

1. Identification of what has, and has not, worked. Describe actual role of each service provider for this child, during this service period, and response of child and family.
2. Overall status of child at this time.
3. Hypotheses/explanations for limited progress, using above parameters for reassessment. Relevant dimensions must be discussed, not just identified.
4. Treatment modifications, if any, already made within current service period.
5. Proposed modifications (beyond just continuation/addition of services) for requested service period.

# PRACTICE

## EXPECTATIONS FOR ALL INDIVIDUALIZED COMMUNITY-BASED ENHANCED MENTAL HEALTH SERVICES

Individualized community-based enhanced mental health services can be used in the home, community or school, separately or in combination, as medically necessary. The child's emotional or behavioral disturbance should be carefully evaluated along the following parameters: thought, mood, affect, judgment, insight, impulse control, psychomotor retardation/excitation, physiological functioning, cognitive/perceptual abilities, psychosocial functioning as manifested in interpersonal and social skills, and motivation. Social contexts, such as home, school and neighborhood/community must be understood in order to determine the appropriate sites of services as well as the resources within each context. Service planning determines the unique combination of services that are medically necessary for the child: individualized community-based mental health services and/or traditional mental health services, plus natural supports.

The following represent specific expectations regarding the use of all individualized, community-based enhanced mental health services subject to this document. Treatment and its documentation should be consistent with the following:

- Nature of emotional or behavioral disturbance, mental illness, or serious at-risk status is clear and is clearly demonstrated.
- Each proposed or used mental health service has a clearly documented rationale, with a specific role in addressing the child's medically necessary needs. Services, separately and in combination, constitute the least restrictive and least intrusive services that are medically necessary.
- Service decisions are substantially determined by an interagency process based on child-driven needs.
- Proposed treatment is demonstrated to meet identified, individualized needs and strengths, addressing the child's development in multiple life domains.
- Ongoing efforts are being made to use community resources whenever possible.
- Parents and guardians have requested or otherwise support use of proposed services.
- Proposed treatment involves a plan, and subsequent demonstrated efforts to implement plan, with active participation by parents, guardians and other responsible adults.

- Treatment involves teaching and support of efforts by parents, guardians and other responsible adults, and other activities specifically identified within the treatment plan as appropriate for involved mental health staff, rather than substitute care.
- Treatment involves ongoing integrated and supervised efforts by all service providers, including a clinical case manager.
- Potential medication needs are being addressed or considered.
- Lack of improvement within a level of care is subject to careful clinical and systemic analysis by the team, prior to either an increase or decrease of services or change in level of services.
- Exceptions to any of the above are clearly identified with explanation or rationale, and discussed within the interagency team.

## EXPECTED PRACTICES WITH “WRAPAROUND SERVICES”

### 1. Designated lead case manager

- a. Coordinates services, reviews adequacy of services, consistency of service provision.
- b. Addresses systemic barriers to treatment and more effective service provision.
- c. Reviews progress with the child and family and all service providers, between interagency team meetings.
- d. Informs professional team members if change in level of care or placement appears imminent.
- e. Interacts with other systems administratively as needed (e.g., with juvenile justice and child advocate office) to ensure that the child receives necessary services and protections.
- f. Sets up quarterly interagency meeting, more as indicated. Contacts all expected members, reinforcing necessity of attendance.
- g. May serve as facilitator of interagency meetings.

### 2. Designated lead clinician:

- a. Is an outpatient therapist, Mobile Therapist (Behavior Specialist only under special circumstances).
- b. Is responsible for clinical overview of case. Is key regular clinical resource for the child and family.
- c. Coordinates own clinical efforts with those of other mental health workers.
- d. Ensures that prescriber has critical information about the child necessary to document need and progress.
- e. Contacts prescriber or designated psychiatrist during crisis or emergency.
- f. Implements contingency crisis plan when necessary.
- g. Collaborates clinically with other systems as needed to ensure appropriate exchange of information and to ensure that the child receives necessary services and protection.
- h. Ensures appropriate opportunities for family participation.
- i. Facilitates treatment team meetings. Possibly facilitates interagency meetings (determined by team).

**3. Institutional supervisor:**

- a. Meets at least monthly with lead clinician and other EPSDT mental health workers.
- b. Ensures that treatment and services are integrated within mental health, and between involved systems.
- c. Reviews implementation of family participation, cultural competence, strengths-based approach, appropriateness of prescribed services, adequacy of treatment plan, adequacy of contingency crisis plan, ongoing promotion of family self-sufficiency, specific outcomes to date, and plan to taper services when indicated.
- d. Reviews response of treating system to crises or emergencies.
- e. Ensures that, whenever possible, critical decisions are made by treatment and interagency teams, not a single individual.
- f. Ensures that community-based mental health workers (e.g., MT, BSC, TSS persons) meet together periodically with the child and/or family in a community-based setting (most often home) to reinforce/review overall progress of treatment plan and to reinforce staff's complementary roles in promoting desired outcomes.

**4. Expectations for interagency team meeting:**

- a. Attendance of relevant family members.
- b. Encouragement of the family to invite extended family and/or valued community supporters.
- c. Attendance of all relevant human service and educational individuals.
- d. Attendance of other relevant professional mental health persons.
- e. EPDST service providers bring copies of progress notes since start date of current service period.
- f. EPSDT service providers bring log of actual service days and hours provided since start date of current service period.
- g. Designated team member serves as facilitator of interagency meeting, following clearly established protocol and ensuring participation of all members. Protocol incorporates discussion of progress as well as problems, review and revision of treatment plan, review of contingency crisis plan, determination of continuing treatment and service needs, strategies and tasks for implementation, scheduling of follow-up meetings.

## THIRTEEN LESSONS ABOUT BHRSCA, BASED ON FEE FOR SERVICE AND MANAGED CARE

1. Services do not necessarily assure desired outcomes.
2. As with any complex entity or undertaking, the various parts of the behavioral health response must all function effectively, in harmony with each other.
3. Desired outcomes require *comprehensive psychiatric/psychological evaluations*, with *prerequisite allocation of time* for pursuit and completion.
4. Genuine individualized treatment requires that team members subordinate their specific allegiances to the actual needs of the child, and that the system of care creates incentives for such child-centeredness. (c.f. “The Real Impartial Review”).
5. Interagency team meetings need to represent a point of hopeful departure for the child and family, not just “the same old meeting” with a new name and new services—through use of a collective envisioning process.
6. An effective system of care supports information exchange and periodic meetings among service providers, not just the fulfillment of their direct service roles in isolation.
7. A review of positive outcomes confirms the importance of parent-professional collaboration.
8. Desired outcomes require a treatment plan responsive to the child and family needs, which actually guides treatment—by identifying specific roles for all parties (child, professionals, and parents); systematically documenting progress; being “alive” during sessions and in the home; and being subject to revision as appropriate in order to incorporate new learning.
9. Desired outcomes require that consideration of psychotropic medication for serious emotional disturbances be validated by the team, and not be solely the domain of the psychiatrist.
10. Desired outcomes and cost containment are facilitated through the use of case management, yet the service-sparing potential of this service is frequently overlooked.
11. Desired outcomes depend on a commitment to shift the intervention balance, over time, from services to resources and natural supports.
12. For its long-term vitality, the public system needs to develop mechanisms that support the long-term tenure of both behavioral health professionals and behavioral health support staff, and the development of a positive public sector culture.
13. Quality improvement requires genuine dialogue among providers, counties, and MCOs, so that issues in need of attention can be identified.

## STRENGTHS-BASED TREATMENT OF CHILDREN What It Is and What It Isn't

### Introduction

Strengths-based treatment involves a commitment to work with the strengths and competencies of children, adolescents and their families, as well as with the strengths of the neighborhood and community and the strengths of all involved child-serving systems. Through an inclusionary, collaborative process among all these partners, meaningful change can be achieved, even for children with a serious emotional disturbance.

Strengths-based treatment can be viewed as encompassing two inter-related sets of factors: *attitudes and beliefs*, on the one hand, which influence how individuals think, and *specific practices*, on the other, which directly affect the mental health treatment and services received by the child and family. Often, the attitudes and beliefs that individuals bring to the table go unrecognized. Similarly, practices may occur routinely without careful consideration of its most and least helpful aspects.

In what follows, the dimensions of *professional attitudes and beliefs* and then *specific staff practices* are broken down into component parts in three separate tables. Each element (attitude and belief, or practice) is analyzed from a strengths-based perspective and from a non-strengths-based perspective. Specific staff practices are further broken down into two aspects of the treatment process — *interagency and treatment team meetings*, and *assessments and ongoing treatment*.

It is hoped that these tables will encourage providers, practitioners and teams as a whole to explore their prevailing ideas and practices, making changes when appropriate in support of strengths-based treatment.

### Attitudes and Beliefs by Professionals

<b>Strengths-Based</b>	<b>Not Strengths-Based</b>
1. Recognition of the child’s parents as competent and caring.	1. Presumption of incapability by parents.
2. Appreciation that caution toward professionals, if present, may be an appropriate response to past experience.	2. Regarding caution as “resistance,” lack of readiness, or character-based hostility.
3. Recognition of the primary expertise of parents, who are full partners in treatment, in relation to their child.	3. Parents seen as obstacles to treatment, or as entirely dependent on the expertise of professionals.
4. Recognition of children and adolescents as resilient, with desire for approval from adults, and capacity to make choices of their own.	4. Children seen as fragile or unreachable and unable to make meaningful personal decisions.
5. Mental health, other human service professionals and educators seen as offering essential experience and willingness to collaborate.	5. Other professionals seen as part of the problem, or as pursuing own agenda (saving money, avoiding responsibility, etc.).
6. Recognition that every child’s community contains valuable resources to be tapped.	6. Certain communities seen as entirely negative without countervailing resources.
7. Recognition that effective treatment involves intrinsic (non-professional) resources, not just professional services.	7. Continuing dependence on services and professionals to produce change.
8. Recognition that specific racial and cultural factors influence the treatment process and that the child’s cultural heritage and practices need to be understood and respected.	8. Belief that “everyone is the same,” and that good intentions without awareness of culture are sufficient.
9. Commitment to a multi-level understanding of the child, encompassing the child, family, community, helping systems, culture.	9. Belief that understanding of single dimension(s) is enough — e.g., child biologically or emotionally, family, etc.
10. Commitment to consensus building among key participants as essential to effective treatment and service determination.	10. Belief that experts alone are best equipped to make clinical decisions, and that involvement of others will hinder the process.
11. Belief that meaningful change is attainable; problems are barriers to progress, not fixed pathology.	11. Problems seen as result of regression, fixation and pathology. Tendency to fix blame.

**Staff Practices: Interagency and Treatment Team Meetings**

<b>Strengths-Based</b>	<b>Not Strengths-Based</b>
1. Meetings include parents and child.	1. Professionals conduct meetings alone.
2. Other non-professionals chosen by family are present.	2. Community resource persons not used.
3. Initial focus on strengths and/or progress.	3. Immediate discussion of problems and failures. Tendency toward blaming.
4. Development of agenda for meeting.	4. Absence of structure for meeting, or of organized approach to problem solving.
5. Parents participate in discussion.	5. Parents sit quietly without participation. Professionals do not seek out parents' ideas. Parental comments disregarded when offered.
6. Professionals are real and accessible.	6. Professionals use jargon, distance themselves from the family being served.
7. Tolerance for multiple viewpoints, effort to resolve disagreements.	7. Intolerance of disagreement, leading to disqualification of speaker or suppression of disagreements. Fears of being "politically incorrect" silence thoughtful discussion.
8. Team agreement on collective mission, based on supporting normal development of the child.	8. Separate agendas continue, without reaching consensus on common mission.
9. Identification of goals and barriers, with plan to overcome barriers.	9. Lack of comprehensive planning.
10. Incorporation of relevant cultural, racial and economic factors into treatment understanding and planning.	10. Failure to recognize cultural dimension or disregarding its relevance.
11. Delineation of follow-up responsibilities.	11. Lack of clear blueprint for follow-up tasks and responsibilities.

### Staff Practices: Assessments and Ongoing Treatment

Strengths-Based	Not Strengths-Based
1. Information on strengths obtained. Use of a strengths-based assessment protocol	1. Information on child and family strengths omitted or perfunctory.
2. Parents invited to participate in evaluations or assessments of the child.	2. Evaluations of the child involve the child alone.
3. Professionals share and request information about the child freely from the parents.	3. Lack of feedback to parents about the child's progress. Lack of interest in parents' expertise, for information about the child.
4. Parents participate in development of treatment approaches.	4. Professionals develop treatment approaches alone.
5. Parents given opportunity for hands-on role in treatment.	5. Role of parents confined to periodic formal meetings.
6. Treatment promotes positive relationships, not just immediate improvement in behavior.	6. Focus on behavior alone, without attention also to supporting primary relationships needed to sustain improvements.
7. Parents participate in monitoring treatment and in determining continuing service needs.	7. Parents experience themselves as "out of the decision-making loop."
8. The child or adolescent given opportunities to participate actively and to make meaningful decisions.	8. The child or adolescent seen as incapable of meaningful responsibility, or as intractably resistant.
9. Professionals support parental competence and teach specific skills as appropriate.	9. Professionals and support staff continue to perform tasks that can, with teaching or training, be transferred to parents.
10. Professionals link family to community resources, facilitate referrals as needed.	10. Continuing over-reliance on professional services rather than increasing use of normalizing community resources.
11. Incorporation of relevant cultural, racial and economic factors into ongoing treatment planning and implementation.	11. Failure to incorporate cultural dimension into ongoing treatment.
12. Services used only as needed, with commitment to work toward increasing sufficiency of family.	12. Continuing use of large quantities of service without appropriate reductions based on progress and changing circumstances.

## THE ROLE OF NATURAL SUPPORTS IN BEHAVIORAL HEALTH TREATMENT FOR CHILDREN AND ADOLESCENTS

### **INTRODUCTION:**

*Natural supports* are those resources being used—or potentially available for use—by the child and family within the community, which do not involve formal behavioral health services, and which are consistent with the cultural beliefs and practices of the child and family. Natural supports may involve activities, community institutions, key resource individuals outside the immediate family, community beliefs, and a variety of informal supports found in the neighborhood or larger community. Natural resources are external to the child and family and, once accessed through active affiliation, become part of the child's and family's strengths. While behavioral health professionals and other involved staff need to become familiar with a child's and family's natural resources, it is important to appreciate that the child and family themselves are often most informed about their own community.

In the discussion that follows, some relevant issues related to natural supports are addressed through a question and answer format.

### **KEY QUESTIONS RELATED TO NATURAL SUPPORTS:**

*How can natural supports help a child with Schizophrenia, Bipolar Disorder, or ADHD? These disorders are all physiologically-based.*

No one can reasonably claim that natural supports will “cure” any of the above disorders, and effective treatment of these disorders involves mental health services and medication. However, this is only part of the story.

Natural supports help to normalize the child's life. As the child's life becomes more normalized and more “typical” of that of others, the child becomes less isolated and lonely. Participation in appropriately-chosen activities—such as a summer reading program, Scouts, a YMCA/YWCA program—enables the child to expand interests and experience competence and spontaneity. If the child participates in a self-help group, the child gains information about the disorder and how others constructively deal with it. Such information may increase readiness to overcome the sense of stigma, accept help, and agree to medication. All of these experiences can increase the individual's motivation and hopefulness—critical dimensions of recovery. Finally, normalized experiences sometimes decrease actual symptomatology. It is as if the individual with social connections is better able to block out intrusive symptoms, or perhaps the social connections actually diminish the symptoms.

Natural supports also can also help the child's parents. For example, a minister or rabbi can help parents deal with spiritual questions that may arise when a child has a serious emotional disturbance (SED). Self-help groups for parents can be invaluable in sharing information and offering support. Neighbors and extended kin can help during times of crisis, and also offer the parents some time alone, by staying with the child in question or all of the children.

Finally, it should be appreciated that natural supports are important not just for children with

SED, but for all children. It is through use of natural supports that the child develops friendships, community ties, and competence in the real world.

*Do natural supports constitute an alternative to behavioral health services?*

To some extent, perhaps, but the most critical function of natural supports, especially in the beginning, is to enhance the treatment process rather than to replace it. The child with SED with meaningful natural supports still typically needs specific behavioral health services. Natural supports are not expected to eliminate the need for these services or to replace professional functions.

On the other hand, a child with community connections might not need an on-site after-school program, while a less connected child might need such a program. Similarly, the child with SED and natural supports may be able to be maintained in the community rather than require inpatient psychiatric hospitalization. If the child receives TSS services, it is possible that fewer hours of this service will be required, and the service can be used in part to support the child's participation in community activities and programs.

*What is the typical progression of natural resources, in well-managed treatment?*

Use of natural resources is often limited during a crisis, or when services are initiated. However, even at this time, consideration of available or potentially available community supports should occur, so that the treatment offered is holistic. Over time as symptoms and behaviors stabilize, there is additional opportunity to explore those individualized natural supports suitable to the child and family. With a continuing core of behavioral health services often including medication, the balance between professional services and natural supports shifts over time. This shift in balance enables services to be tapered and eventually discontinued. When there is total or primary reliance on behavioral health services, it may never seem like the right time to discontinue services, and the transition, when it does occur, may be difficult.

*What are some ways that use of natural supports is documented in a child's clinical record?*

The use of natural supports can be documented in many ways. For example, the psychological or psychiatric evaluation can identify natural supports under *Identifying Information* and elaborate further in the *Strengths* and *Community* subsections of *Relevant Information*. The role of these supports in the overall treatment process can be addressed in the *Discussion* section. Suggestions for augmentation can be offered in the *Recommendations* section. Use of natural resources will be reflected in the child's Plan of Care Summary.

Natural supports can also be identified within a strengths-based assessment report of the child and family. This report, therapeutic in its own right, greatly expands the database. A strengths-based assessment, if identified in the treatment plan, can be undertaken by an outpatient therapist, Mobile Therapist, or Family-Based or other mental health professional, and can build on the initial psychological or psychiatric evaluation.

A comprehensive treatment plan incorporates the use of natural supports. Resource persons, and not just behavioral health professionals and support staff, are identified as contributing to the child's treatment. For example, some interventions can be promoted by an identified resource person. Similarly, some activities identified as objectives for the child can involve participation in community activities or programs. Natural resources can even serve as potential rewards for the child.

*How are natural resources identified?*

This is an important question that is intimately linked to each CASSP Principle: #1 (the individualized treatment of the child), #2 (the need for family participation), #3 (responses that are community-based), #4 (the use of multiple systems, which includes non-professional resources), #5 (culturally competent responses), and #6 (least restrictive and least intrusive responses). No community is without natural resources, just as no individual is without strengths. The first authority on community resources is always the family itself. In addition, it takes professionals who are knowledgeable about communities in general and the child's community in particular to assist in the identification process. The case manager can play an indispensable role here. TSS workers, when involved and from the community, often have an important contribution to make. In general, the training of many mental health professionals tends to overlook the need to identify and incorporate community resources into the treatment process.

*How else can we tell if we are effectively using natural resources?*

The proposed budget for services will include some allocation for natural supports—for example, funds for a YMCA membership or another activity. The actual amount need not be significant; but its presence reflects a comprehensive planning process. Finally, when natural supports are used, the number of resource persons for the family increases. These individuals, at the behest of the family, can participate in interagency and treatment team meetings. Count heads at the team meeting. How many attendees are there who are not professionals, the child, or the nuclear family? Perhaps this is a litmus test of community participation, and incorporation of natural resources into behavioral health treatment.

## “PRESUMING THE POSITIVE” AS PART OF STRENGTHS-BASED TREATMENT IN WORKING WITH CHILDREN AND FAMILIES

### INTRODUCTION:

In behavior health treatment, where behaviors, interactions, and motives can be interpreted in many possible ways, the orientation and assumptions of the practitioner become crucial. In fact, the practitioner’s beliefs strongly influence what may mistakenly be viewed as objective assessment. This article explores the importance of “presuming the positive” toward those with whom we want to collaborate, especially families. Two clinical situations are presented, the first involving a mother and son, the second a psychiatric consultant and an adolescent. We consider the difference between observation and interpretation, offer useful assumptions for working with parents and with children (up to age 21), and consider the broader implications of this strengths-based approach.

The phrase, “presuming the positive,” is intended to convey two related concepts. First, during initial contacts and in neutral situations, there is a presumption of competence and good intentions on the part of one individual toward the other. Second, in situations of uncertainty and ambiguity, the individual postpones immediate judgment and offers the other party what is commonly called “the benefit of the doubt,” once again presuming competence and good intentions.

### SOME EXAMPLES WITH DISCUSSION:

#### Example I—Interactions Between a Mother and Son:

*Ms. Holly Allen, a 34-year-old Caucasian female, brings in her 11-year-old son, Joe, who is uncooperative at home and increasingly aggressive at school, for outpatient therapy. Joe was recently diagnosed with ADHD and is about to begin treatment. Also present is Joe's younger sister, Sally, age 8. Approaching the family in the waiting room, Mr. Ralph Walker, the therapist, observes Ms. Allen to be frowning at Joe and yelling at him.*

*In the office, Mr. Walker, consistent with his training, asks Ms Allen about Joe’s strengths and capabilities. To his frustration, Ms. Allen replies, “I’ll tell you what’s wrong with this child. He has no respect. And he has no common sense either. I can’t remember the last time he did something right.” Immediately, Joe shouts out, “You should talk,” after which Ms. Allen angrily shouts, “Must you always cause trouble?”*

#### Differentiating Observation and Interpretation:

It is important to recognize the difference between *observation*, which serves as an important source of data, and *interpretation*, which involves the meaning ascribed to the data and gives rise to assumptions about the motives and capability of others. In the above example, the therapist observes Ms. Allen being impatient with and critical of her son, Joe. She does not identify his strengths upon request. Their relationship is clearly strained. These observations are part of the therapist’s data. However, at this point, the process remains incomplete.

What is to be made of the above data? The way data is interpreted is always crucial, because it

shapes a therapist's point of view about a parent or family, which in turn influences the therapeutic relationship in many ways. Consider the difference between the following two interpretations of Ms. Allen and her relationship with her son:

**Interpretation 1** (a traditional non-strengths-based perspective);

*Ms. Allen cannot control her son, and appears to have very limited parenting skills. She yells at him, criticizes him constantly, and has nothing positive to say about him. While there is no evidence of abuse going on, it's not hard to imagine why Joe is angry with his mother and does not cooperate with her.*

**Interpretation 2** (a strengths-based perspective):

*Ms. Allen is very frustrated with her son right now. I don't know exactly what is going on, but I do know that all parenting has its ups and downs, especially with a pre-adolescent. Also, Joe is a very impulsive 11-year-old with untreated ADHD, who appears to be extremely challenging. I believe that the observed interactions represent only a small part of the relationship between Ms. Allen and Joe. I need to find a way to learn more, before drawing more conclusions.*

We can appreciate that the first interpretation would lead the therapist in one direction (for example, he might start giving the “incapable” Ms. Allen lessons in parenting, based on very limited data suggesting such a need), while the second interpretation could give rise to very different interventions (for example, the therapist might continue to listen respectfully to Ms. Allen’s concerns, and then ask both mother and son to describe “what it used to be like,” when things were better). Data (e.g., direct observation, information from others, and written material) comes without interpretation and therefore is neutral. Once meaning about motives and capability are ascribed to the data, an interpretation is made, which combines observation and inference. Interpretations inevitably affect both assessment and subsequent treatment, for better or worse. A strengths-based therapist, mindful of the limited information available and seeking to help the family out of their stalemate, will presume the positive and offer mother and child the benefit of the doubt.

### **Example 2—A Psychiatric Consultant and an Adolescent Who is Hostile**

*Dr. Robert Kahn, a school-based psychiatrist, is asked to consult on Nick, a 15-year-old African American male who has been getting into fights with peers, resulting in a recent suspension. Nick's mother has consented to the consultation but is not available to participate. She will come in the following week.*

*Nick lives in the inner city with his mother, stepfather, grandmother, and two younger half-sisters. An older brother was killed three years ago in an apparent drug-related conflict. Nick's grades and behavior went down after that. With fluctuations since then, Nick has never regained the honors status he had regularly achieved earlier.*

*When seen by Dr Kahn in his office with the primary teacher, Nick was hostile. He said that he had no problems, and insisted, “I don't need to see no shrink.” When asked about interests, Nick replied, “It's none of your business, man.” When the teacher expressed concern about the most recent assault, Nick responded, “That dude had it coming. He's a jerk. Next time I'll hurt him worse.”*

### **Differentiating Observation and Interpretation:**

Once again it is essential to recognize the difference between observation (data) and interpretation (the possible meanings to be ascribed to the observed data).

**Interpretation 1** (a traditional, non-strengths-based perspective):

*Nick is a delinquent adolescent with extreme impulsivity, little or no insight, and an inability to accept responsibility for his behavior. He is not able to trust others, and I probably will recommend a transfer to a school for delinquents.*

**Interpretation 2** (a strengths-based perspective):

*Nick is not easy to get to know. I expect that it will be easier when his mother comes in, but in the meantime, I've got to try to make a better connection with him. This is a child who used to make honor roll. He lost his brother to the streets. I guess he needs to be real careful about letting down his guard.*

The first interpretation could lead the consultant into a confrontational stance with Nick, based on an assumption that he has to “be tough” with this type of teenager. Alternatively, the consultant could back off, assume the worst, and then recommend Nick's removal from the school.

The second interpretation once again leads to a more constructive direction. By recognizing the emotional and culturally based protections that Nick's bravado offers him, the consultant chooses not to confront Nick angrily, nor to withdraw from him either. Instead, he seeks ways to strengthen the interpersonal connection. For example, in an effort to build on strengths while also providing Nick a chance to get comfortable, Dr. Kahn could say to the teacher, “Tell me about some of the things that Nick does well.” Alternatively, Dr. Kahn could say to Nick, “I understand that you're a pretty private guy, and that makes sense to me. I'm pretty private also, much of the time. That's not a problem for me.” In support of the therapeutic relationship and consistent with the need to gain time and additional information, the consultant presumes the positive and offers Nick the benefit of the doubt.

### **SOME HELPFUL ASSUMPTIONS FOR WORKING WITH PARENTS:**

An individual's *presumptions* at a particular moment of interaction are in large measure a function of that individual's beliefs or *assumptions*. I carry with me a set of assumptions about families that goes back to 1977. That year, after completing my fellowship in child psychiatry and before my introduction to CASSP, I formulated “The Four C's.” The Four C's are assumptions about families and how therapy should work. In retrospect, these assumptions appear quite consistent with what we now know as CASSP Principles. The Four C's are relevant to a therapist meeting and working with a child and family around a child-centered concern. Before and during a meeting, the strengths-based therapist makes the following four assumptions about the child's parents and family. The parents are seen as:

*Caring:* Parents genuinely care about the child, and want to do the right thing. When this is recognized and acknowledged by a mental health professional, the therapeutic alliance is greatly strengthened.

*Competent:* Parents are competent, even if this is not immediately evident in every instance. This competence needs to be recognized and supported, and in combination with the caring forms the foundation for positive change.

*Caught:* To some extent, barriers are interfering with the parents' promotion of the desired development and functioning of the child, creating frustration for all parties. These barriers need to be identified and addressed.

*Changing:* Families are always changing, and desired change can occur, to identify and help overcome current barriers. The newly-forming therapeutic system represents a dynamic structure that can influence the change process positively.

Implicit in these assumptions is a recognition that the “solution” does not reside in the therapist but in the family itself, the relationship between therapist and family, and the ideas generated from that relationship. Thus, effective therapy involves a partnership and the sharing of power. As stated in 1996 by Borden and Fine, effective collaboration between therapist and family requires “respect for the expertise that each brings to the relationship” (p. 3). I continue to rely on this formulation in my current work, because shared problem solving is ethically sound and also promotes a mutual sense of optimism about the possibility of making a difference.

### **SOME HELPFUL ASSUMPTIONS FOR WORKING WITH CHILDREN AND ADOLESCENTS:**

Recent articles by this writer in *Sharing*, the newsletter of Parents Involved Network, articulated important assumptions for those working with children and adolescents who are defiant. These are now restated as follows:

- *Children and adolescents are always listening, regardless of how they may appear or what they say.*
- *Children and adolescents tend to fulfill the expectations of those important to them.*
- *Children and adolescents tend to follow behaviors that they observe in important others.*
- *Children and adolescents respond best when treated respectfully and with a presumption of their positive intentions.*

Implicit here is an appreciation that children are always engaged in a process of development, and that development entails the possibility of growth, change, and resiliency. While some children have social-emotional limitations, the functional capacities of these and other children can be promoted through the consistent provision of respect, support, positive expectations, patience, and positive life experiences.

### **DISCUSSION: IMPLICATIONS FOR WORKING WITH FAMILIES WHERE CHILD PROTECTION ISSUES EXIST:**

The presumption of competence and positive intentions, as embodied in the Four C's, should apply to all families, even those where there are child protection issues and a possible history of abuse. Child protection agencies, to be sure, need to address issues related to the safety of children. Some families will require services, supports, and monitoring. In some cases, the removal of a child from the family may be necessary.

However, the implication of “presuming the positive” as part of a strengths-based approach is that, even in families where safety is a legitimate concern—perhaps, especially in such situations—we need to ascertain strengths and competencies and to respond to the family with respect. We should listen

to caregivers' attempts to articulate their goals for their family, even if the goals deviate from the present reality. As Weick and Saleeby point out, "We cannot know, at the outset, the upper limit of any family's potential. We cannot deny the reality and possibility of any family's aspirations" (p. 147). While immediate interventions may need to be guided by child protection concerns, the family should not be disregarded, nor should future possibilities be dismissed. The authors continue:

*All families, regardless of their structure or history, have valuable capacities, resources, skills, motivations, and visions that must be tapped in helping them gain more control over their daily lives (p. 148).*

By attending to family strengths and presuming the positive with regard to parents' expressed goals and aspirations, representatives of child-serving systems best meet their responsibilities to both the child and the parents. Another critical step involves helping the family connect to natural supports within the community and not just to professional services, as part of the helping process. The need to link the family to the community is based on the assumption that, ultimately, it is the community that "forms the basis of the empowerment process" (p. 146).

### **CONCLUSION: "PRESUMING THE POSITIVE" AND OFFERING "THE BENEFIT OF THE DOUBT":**

In each of the clinical examples offered above, a strengths-based approach to treatment entails "presuming the positive" and offering parents and children "the benefit of the doubt." In the first situation, we presume that Ms. Allen, despite her evident frustration, cares about her son Joe and is a competent parent. Her immediate frustration has brought out just one facet of her parenting. We also presume that Joe wants things to be better. With such a mind-set, a strengths-based therapist can promote positive outcomes by building upon the caring and competence of both parties.

Similarly, we support Dr. Kahn's presumption that 15-year-old Nick, like most teenagers, has both a capacity to relate to others and a desire to do to, once he feels emotionally safe. A strengths-based perspective alerts the psychiatric consultant to possible circumstances that help explain Nick's hostility, and he offers Nick respect and additional time, in order to develop a therapeutic relationship.

Thus, whether actively recognized or not, assumptions about parents, children, and families profoundly influence each practitioner, irrespective of that individual's specific discipline or role in care. Interpretations of data, in turn, can be either helpful or harmful to treatment. Particular pitfalls for professionals involve a tendency toward premature interpretations and a tendency to become overly organized by negative interpersonal events. Ultimately, a therapeutic perspective involves balanced recognition of both strengths and limitations. However, given the predisposition to notice and hold onto the negative, we must undertake active efforts to ensure that our presumptions do not undermine our capacity for unbiased data gathering, and we must carefully interpret our data, prior to drawing conclusions. We can compensate for the many pulls toward pathology by presuming the positive in our dealings with others.

Strengths-based responses that presume the positive and offer the other person the benefit of the doubt in matters of ambiguity and uncertainty build on strengths and promote trust, collaboration and mutual respect. Such responses also spark motivation. We have seen that such an approach is relevant to a practitioner's relationships with children, parents and families. Two corollaries should also be recognized:

1. Presuming the positive is equally applicable to the practitioner's relationships *with other behavioral health practitioners and with representatives of other child-serving systems.* It

should be presumed that each participant wants to contribute positively.

2. Presuming the positive is applicable to *the child or parent* working with the mental health practitioner and other child-serving system representatives. The approach works best when it is reciprocal, rather than unilateral in nature.

Presuming the positive does not guarantee that every encounter among participants will be mutually satisfying. We know that disappointments occur. Nevertheless, it represents a hopeful stance that can be self-fulfilling in a positive way. The bottom-line of this principle, regardless of specific participants and setting, can be summarized as follows:

*By presuming the positive and offering others the benefit or the doubt, we help to remove doubts that they may also have about us, thereby moving a desired process forward.*

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## BUILDING BLOCKS OF THE CLINICAL INTERVIEW

1. **Respect:** An attitude of positive regard and a manner of positive relating, achieved in the following ways: developing genuine connections; putting the child and/or child and family at ease; conveying a non-judgmental, non-blaming attitude; creating a sense of physical and emotional safety; demonstrating interest and availability. Assume that the child and family want things to improve.
2. **Curiosity:** Interest in learning about child and family culture, beliefs, experiences, routines, coping, sources of support. Interest in understanding the current dilemma/obstacle to the child's emotional growth, its precursors, and efforts to address. Willingness to learn, not just lead.
3. **Listening:** Readiness to elicit, and listen to, the child and family experience, in their own words. Listening entails avoidance of unnecessary interrupting of the child and family, and of premature conclusions by the evaluator. In an effort to become immersed in the child and family experience, from their perspective, the evaluator facilitates information-sharing through guiding questions and gentle reflection, when necessary. Challenges and presentation of alternate points of view are deferred.
4. **Searching for patterns and hypotheses:** Behavioral health treatment is predicated on the assumption that interpersonal events do not occur randomly but instead have explanations and occur in patterns. The evaluator works with the child and family as a "detective," searching for patterns and hypotheses that lead to greater understanding and to useful treatment interventions.
5. **Supporting competence:** The evaluator supports, directly and indirectly, the competence of the child and family. Such support is conveyed through respect, curiosity and listening, identifying child and family strengths, and in other ways. Care must be taken to support competence without inadvertently minimizing or disqualifying child and family concerns.

## THE SATISFACTION QUESTION

Child and family satisfaction with mental health treatment is imperative for both ethical and pragmatic reasons. There is an ethical imperative that the child or adolescent and family experience the process as respectful, participatory and helpful. They are, after all, the individual and family being challenged, whose lives are most affected by the outcomes. Pragmatically, mental health treatment cannot be viable unless they choose to trust the clinician, share actual concerns, continue attending, and implement suggested changes. Without the active support and participation of the child, parents and other designated caretakers, mental health expertise is academically but not practically beneficial.

Child and family satisfaction is relevant not only at the end of treatment but also while the process is occurring. During clinical interviews, both the ethical and practical imperatives for child and family satisfaction can be promoted in the following ways:

- Mental health treatment is respectful, recognizing the knowledge of parents and caretakers, and the capabilities of the child and family;
- Identified concerns are clarified and addressed, with the mental health professional listening and asking questions, not just informing and directing;
- There is clear commitment to build on identified capabilities and strengths;
- The decision to broaden the therapeutic agenda and to address other relevant issues is mutual between the family and the professional, based on a joint exploration and negotiation, with the child or adolescent's desired outcomes in mind;
- The mental health professional is alert to therapeutic process (e.g., how the child may be experiencing the immediate event), so that access, voice and ownership are all valued and promoted.

There is a specific technique I have found useful in promoting child and family empowerment during the clinical interview, especially during the initial contact between the child and family and me. The interview in question may be a specially requested clinical consultation, a psychiatric or medication evaluation of the child with family participation, or a wraparound meeting. I call this technique "The Satisfaction Question."

The Satisfaction Question is simple and straightforward. Early in the interview, but after initial efforts to get to know the family and help them feel comfortable, I ask the following question: "What needs to happen during this interview so that, when it is over, you will feel satisfied and able to say, 'This meeting was really helpful to us'?"

Families respond positively to the Satisfaction Question because it makes them immediate stakeholders in the direction and outcome of the interview. Their responses assist me and other participating mental health or human service persons by orienting us to the family's key interests. Through feedback, I can inform the family which goals appear realistic for the immediate session, and which are likely to require additional efforts. This input can be discussed, as needed, promoting honest exchanges and the establishment of rapport. The interview can then proceed in a highly focused yet comfortable manner.

Whether or not other professionals find the Satisfaction Question beneficial, it is important that each individual remain alert to ways to create a partnership at the beginning of treatment and throughout treatment. Children and families depend on it.

## IN SUPPORT OF GENUINE PARENT-PROFESSIONAL COLLABORATION

In children's mental health, the initial assumptions of the helper (the mental health professional or the mental health worker) are critical, arguably as important as anything that follows. When parents bring in a child with an emotional or behavioral problem, does the helper assume that the parents are truly committed to the child and doing the best they can? Is it also assumed that the family has the capacity to make changes to promote the growth and development and the emotional well-being of the child? Does the helper believe that the family's story needs to be heard? If so, why? Does the helper believe that the family's story provides the basis for developing a meaningful response, through a collaborative effort, to the child's problem?

Affirmative answers to these questions constitute for me the essence of a strengths-based mental health approach. Our assumptions profoundly influence how we introduce ourselves, ask questions, look at one another, think and respond. Being a mental health helper implies having some expertise based on training and experience, but certainly not superiority over those being helped. And, as parents rightfully point out, expertise is not the singular domain of the helper. Parents have unique expertise when it comes to their own children and the challenges of parenthood.

All of this might seem to be old business, but the quest for meaningful collaboration between parents and professionals goes on. Both mental health helpers entering the field and parents seeking mental health assistance need to benefit from valued insights. Beyond this, the nature of the collaborative process itself requires ongoing consideration and additional refinement.

Many mental health helpers have taken the perspective of parents as partners to heart, based on its own merits and often on an intuitive awareness that mental health treatment can only be helpful when there is trust and rapport between helper and parent. Some of these individuals, however, have expressed confusion about how to respond to parents when there is disagreement around a clinical issue. Reticent to verbalize a disagreement, the helper may remain silent. The fear is that, by expressing a different point of view than that of the parent, the helper would be disrespecting and disqualifying the family. If the family knows itself best, the thinking goes, then the job of the helper is just to agree and to help the family achieve its goals as initially expressed. Yet, in withholding their own ideas, these helpers sometimes wonder if they are really serving the family in the best way.

For families who have encountered arrogant helpers who have criticized or blamed them, or simply not listened, it may come as a surprise to hear about other helpers who hold back their ideas out of concern for offending the family. However, for some helpers this dilemma is real, and I believe that it bears some consideration, since it helps illuminate some core elements of the collaborative process.

If we recognize the complexity of human predicaments, we appreciate that it is possible for multiple forces to coexist at the same time. For example, we can be competent but still be uncertain, or stuck, in a particular situation. We can still feel strongly about something at a time of frustration, only to be relieved later on that we did not act on those feelings at the time.

My belief is that the mental health helper is not simply a "pass-through," uncritically endorsing ideas because they emerge from a parent or from anyone else. In like manner, the helper is also not a positivist oracle, holding forth on correct and proper choices for the family to make. The appropriate role of the helper, in accordance with the level of training and agreed upon scope of service for that individual,

is to offer the child and family a sense of realistic hopefulness as well as specific leadership based on the professional expertise. A critical element of leadership is sharing and responding to ideas. The anthropologically oriented psychiatrist Arthur Kleinman (*Rethinking Psychiatry: From Cultural Category to Personal Experience*, Free Press, 1988) describes the psychotherapy process as a “dialectic,” or ongoing exchange, between the family and the therapist. Kleinman regards the family’s alternative knowledge as “comparable to, though different from, [the helper’s] knowledge.” The essence of psychotherapy, he indicates, “should involve a negotiation between lay and professional perspective on the problem.” The end product of that negotiation may differ from the initial ideas of either party.

Professional leadership in response to family concern or uncertainty about the emotional or behavioral difficulties of a child requires more than silence or automatic agreement by the helper. In fact, such passive responses may constitute an abdication by the helper, both of the family and of the helper’s own authenticity. In contrast, the effective exchange of ideas creates an exchange of energy among participants that can be empowering to all, reinforcing a sense of common purpose and community.

Perhaps the real issue of helpers involves not suppressing input but rather delivering it properly. Helpers should express ideas and disagreements *respectfully*. By observing the responses — verbal and nonverbal — of the individual being addressed, the helper can modify the tone as needed. Since an exchange rather than a monologue is essential, the helper should encourage a response and listen carefully. A few additional thoughts may also assist helpers in promoting genuine parent-professional collaboration:

1. Remember that raising a child is not an easy undertaking. For many reasons, children of *all* parents can be at risk to develop emotional and behavioral problems.
2. Defer most input until *after* first listening to the family’s story and asking family members what they believe will make a difference.
3. Remember that trust is built on *integrity*, and that trust increases the capacity of all parties to endure and grow from conflict.
5. Remember that a genuine collaboration is sustained not just by a shared effort *toward* a goal, but by a shared belief that failure to achieve that goal, or a modified version, is unacceptable to all.

## RIGHTS AND RESPONSIBILITIES IN PSYCHOTHERAPY

### INTRODUCTION

In a society in which psychotherapy remains an elusive, mysterious process to many, it is important that its ethical basis be understood. This article is intended for all persons receiving or about to receive psychotherapeutic or related mental health services—and for those providing such services.

Contrary to extreme viewpoint, psychotherapy is neither a panacea nor a surrender. The effectiveness of psychotherapy—whether individual, marital, or family therapy—depends on trusting relationships. Psychotherapy is best understood as a **goal-directed, collaborative** undertaking between therapist and client, here referring to individual, couple, and/or family. The process is maximized when all parties recognize their rights and their responsibilities.

### PSYCHOTHERAPY: STRENGTHENING RELATIONSHIPS

At its root, psychotherapy involves a strengthening of the capacity for **relationships**—relationships with family members, the outside world, and the therapist. When a family member develops symptoms, or when the family experiences other adversity, relationships often become strained. Discouragement may set in. Good psychotherapy addresses this discouragement and helps the family to heal and grow. Despite differences in training and technical orientation, good therapists, I believe, all promote the capacity to form relationships.

### YOUR RIGHTS IN PSYCHOTHERAPY

When rules are clear and fair, we feel secure and may be willing to invest in a process. In psychotherapy, client rights and responsibilities—and the reciprocal therapist responsibilities and rights—constitute the rules of the process. It is the responsibility of the therapist to help ensure client rights, and the responsibility of the client to respect therapist rights. Let's consider four of your most important rights, as I see them, in psychotherapy.

**Telling your story:** You (and your family) have a right to be heard. You have a story to tell and a right to tell it. Therapists differ in how they listen: some wait to ask questions, while others ask questions along the way. In either case, you should be given an opportunity to express your ideas and concerns without a sense of pressure.

**Being respected:** You have a right to be respected, regardless of what has happened. Your strengths, including your knowledge of yourself and your family, should be recognized. The therapist should display empathy—a genuine effort to appreciate your struggles and your aspirations. Humiliation and blaming should be avoided. It is also important to appreciate that, within respectful therapist-client relationships, therapists sometimes need to challenge you, in order to help you recognize and develop a range of constructive choices.

**Developing treatment goals:** You have a right to develop and articulate your treatment goals. The therapist needs to respond to your goals, not set up an independent agenda. At the same time, the therapist is obliged to examine your goals carefully with you, not just accept them perfunctorily. They may need to be prioritized, modified, or reconciled with those of other family members. This process of discussion and negotiation ultimately gives rise to a shared treatment mandate—the agenda for therapy. The treatment

mandate defines the goals and responsibilities of all current and potential participants. In this way, psychotherapy is legitimized as an ethical process to create change.

**Collaborating throughout the process:** You have a right to be an active collaborator in therapy, not a passive recipient of services. Your right to collaborate extends throughout the entire process. Decisions include: selection of participants; agendas for specific sessions; use of consultants (if indicated); use of psychotropic medication (if indicated); frequency of meetings; and termination.

## **YOUR RESPONSIBILITIES IN THERAPY**

You have responsibilities in therapy, not just rights. These responsibilities are to yourself, your family, and the therapeutic relationship. Client responsibilities promote the competence of both client and therapist. Let's return to the four areas discussed above and consider client responsibilities.

**Telling your story:** You need to tell your story clearly so that your needs can be understood. You convey your uniqueness—and your pain—through your personal narratives, as the therapist listens. It is up to you to use the opportunity that the good therapist offers.

**Offering respect:** The therapist deserves respect, as a professional with expertise and as a person. One essential form of respect involves offering the therapist honest feedback. When dissatisfied clients go underground without alerting the therapist, treatment is undermined. In facing conflict with the therapist, clients gain valuable practice for other important relationships. Clients also need to be respectful toward each other. A commitment to maintain physical and emotional safety during sessions promotes a similar commitment for the family at home.

**Developing treatment goals:** Clients need to state their needs clearly and help define treatment goals. Diffuse goals and client passivity usually spell later dissatisfaction. In goal setting, clients and therapists need to share leadership responsibility.

**Collaborating throughout the process:** Once clients recognize that **their** efforts create change, it becomes easier for them to maintain an active, collaborative stance. As noted, collaboration is important not only when the process goes smoothly but also when disagreements arise. The ending of treatment should also involve collaboration. Termination decisions should be discussed with the therapist, not undertaken unilaterally. Termination discussions can be among the most valuable experiences of the entire process.

## **DISCUSSION**

This article is intended to clarify some misunderstandings about the helping process, in particular psychotherapy. Therapists—whether providing services in clinics and offices or in the home and community—and clients alike need to recognize the collaborative nature of psychotherapy. Psychotherapy is unlikely to benefit clients if they are not empowered to participate fully, by identifying strengths and needs, offering insights and expertise, and sharing in decision-making. Given the uncertainty often common to the psychotherapy process, mutual respect and a willingness to work out disagreements are essential prerequisites to a successful outcome.

It should be appreciated that the above identification of client rights in psychotherapy in no way encompasses the full range of client and family rights in the overall behavioral health process, particularly in the public sector. Providers are required to identify and distribute a full range of client and family rights. Children and adolescent behavioral health services in Pennsylvania are required to be consistent

with CASSP Principles. While the client rights identified above are entirely consistent with CASSP Principles, there are many other rights—including client participation during interagency team meetings, not just in psychotherapy; client participation in developing a formal treatment plan; client participation in monitoring treatment; and client and family participation in policy development at all levels—that also require committed attention. In these areas also, mutual respect, collaboration, and shared decision-making are all applicable.

## **CONCLUSION**

Regardless of the complexity of a system of care and the number of available services, it is crucial that there be understanding by all parties of the essence of the helping process. In fact, in behavioral health it can be argued that the more complex the system becomes, the more important it is to return to first principles. Linear models of psychotherapy, with the therapist as the designated expert and the client as the recipient of the therapist's "wisdom," must be revised to a circular model in which expertise and responsibility are shared.

Psychotherapy represents a humane method of empowering people facing emotional and behavioral challenges. Properly conducted, psychotherapy involves a process of inclusion built on trust and mutual respect. By considering participant rights and responsibilities, we can help demystify the psychotherapy process, identifying not just the separate domains of therapist and client but their shared opportunities to create meaningful outcomes that promote competence and positive adaptation to the real world.

## WORKING WITH CHILDREN AND ADOLESCENTS WHO ARE DEFIANT: Unconditional Respect Comes First

### **Introduction:**

Whether you are a mental health professional, mental health worker, case worker, drug counselor, teacher, parent, or other helping individual, working with children and adolescents who are challenging (referred to as children) is not easy. This is especially the case with children who are angry, defiant, or violent. Such children can be frustrating, and have a way of “pulling the strings” of the most well-intentioned individuals.

My intention here is not to outline a complete treatment for working with challenging, defiant children, but rather to identify one precondition for successful long-term intervention -- the provision of unconditional respect. The idea is that, while respect alone may be insufficient to produce desired change, its absence makes meaningful, long-term change highly unlikely.

### **Three Propositions Regarding Children and Adolescents Who Are Defiant:**

Consider the following three propositions:

1. *Children and adolescents who are angry, defiant, and violent cannot be bullied into prosocial behavior. [Prosocial behavior refers to peaceful, socially acceptable behavior by a child or adolescent that does not occur *only* when the individual is being monitored, or *for the sole purpose* of avoiding legal or other adult-based consequences.]*
2. *Children and adolescents tend to behave consistent with the expectations held by important adults in their lives, and consistent with the way that they are treated.*
3. *Both ethically and pragmatically, an appropriate approach to children and adolescents who are defiant includes the provision of unconditional respect.*

On initial glance, these three statements may appear obvious. Unfortunately, however, actual practice in mental health, other helping professions, and education is not always consistent with the thrust of these propositions. In fact, there are some who would argue that “conduct disordered kids” will not benefit from a respectful approach and will endlessly manipulate adults who relate to them in that way. These children, it is argued, need to be “broken down” or “put in their place,” in order to learn that they cannot get away with everything. Within such a framework, attempts may be made to “scare straight” the child, “read them the riot act,” or otherwise humiliate or shame them in some manner.

In order to promote meaningful, long-term outcomes for children who are challenging, let us consider each of the above propositions more carefully.

#### **1. Children and adolescents who are angry, defiant, and violent cannot be bullied into prosocial behavior:**

The humiliation or shaming of children, whether pursued deliberately based on ideology, spontaneously based on an effort to be “real,” or inadvertently (based on lack or awareness or a loss of

self-control), in all cases represents a step backward. Children who are angry and defiant, it must be appreciated, are emotionally vulnerable and are extraordinarily sensitive to imbalances in power, perceived lack of fairness, and situations that cause them to lose face. The more vulnerable the child, the more sensitive to being “dissed” or disrespected.

When perceived or actual humiliation occurs, the child feels compelled to fight back and “get even.” Such retaliation may occur immediately, leading to a crisis, or may be suppressed, only to be expressed at a later time. In the latter case, when the child suppresses an immediate response, the adult may mistakenly conclude that the child has “learned a lesson” as a result of the confrontation. However, there exists what I regard as “a law of interpersonal reactivity,” which plays out with children as follows: Any adult behavior that humiliates a child leads to an equally (or greater) negative, self-defeating response on the part of the child, immediately or some time later. Such “acting out” may lead to further humiliation being directed at the child, who then continues the oppositional cycle of protest through further inappropriate behavior. Upon repeated shaming by an adult, the child does indeed “learn,” but the child’s learning involves a confirmation of the world as dangerous and humiliating, rather than an appreciation of the value of working cooperatively with others.

When violent behavior ensues, according to Ken Hardy, teacher and researcher at Syracuse University, it is often the outcome of rage rather than anger. Rage is a more intense emotion than anger, and is based on long-standing experiences of humiliation and disqualification. When a child’s rage is not acknowledged and addressed, it may lead to violence, loss of empathy, and profound devaluation of human life.

Former prison psychiatrist, James Gilligan, while discussing adult offenders who are violent, offers formulation that applies to children as well. Humiliation and shaming, he explains, increases the individuals devaluation of human life and the likelihood of future violence:

*... the more harshly we punish criminals, or children, the more violent they become; the punishment increases the feelings of shame and simultaneously decreases their capacities for feelings of love for others, and of guilt toward others.*

A vicious cycle is created with violent individuals. Harshness increases the child’s sense of shame and humiliation, which intensifies his/her need to get even violently. The more the child acts violently, the more he/she loses the capacity for empathy and relatedness -- and the harsher the punishment by the adult authority that follows.

**2. Children and adolescents tend to behave consistent with expectations held by important adults in their lives, and consistent with the way that they are treated.**

It is well recognized that people tend to respond according to the expectations of others. A facilitative setting tends to bring out more competent, persistent behaviors, while a non-facilitative setting results in poorer performance and premature giving up. In discussing this pattern in the classroom, Deborah Prothrow-Stith, a physician and public health official in Massachusetts, offers the following comments:

*Social scientists and educators have proven time and again that children tend to perform academically as they are expected to perform. By and large, children who are expected by their parents and teachers to work hard and achieve, do just that. When teachers, administrators, and parents do not expect much, children do not rouse themselves ... Children who are labeled “dumb” tend to become dumb*

to meet the expectations of those in authority. (*Deadly Consequences: How Violence is Destroying Our Teenage Population and a Plan to Begin Solving the Problem*, p. 164).

Given their lack of maturity and their rapid development flux, children are even more susceptible to the expectations of others than are most adults.

Children also tend to incorporate and internalize behavior that they observe and experience directly. The child who is “put in his place” by an adult authority is likely to repeat such behavior, with the same or other adults, and with peers. Despite the bravado of children who claim indifference to what adults may be saying or doing, their antennae are sharp indeed. This is why Geoffrey Canada, the founder of the Rheedlen School in Harlem and a keynote speaker at the 1998 Federation of Families Annual Meeting, has stated that “children are programmed to learn from adults; that’s how our species has survived and prospered” (*Reaching Up for Manhood*, p. 75). It behooves us to remember that such programming implies the possibility of powerful positive influences on children, not just negative ones.

**3. Both ethically and pragmatically, the appropriate approach to children who are defiant includes the unconditional provision of respect.**

The need for respect appears to be universal and cross-cultural. It can be regarded as a fundamental human need. The child denied respect in turn abandons reciprocal, respectful interactions with mainstream adults and develops instead what can be regarded as a secret “code,” which guides future behavior. For some children, behavior becomes deviant in support of activities that may promise respect (e.g., gang membership or drug dealing). For other children, deviant behavior may be less purposeful and represents primarily a protest against past injustices. Dynamics such as these operate with nearly every angry, defiant child, so it is important to take the time to learn about the child’s life experiences, social context, and personal needs, so that eventually the child’s “code” is broken.

A poignant example of such a code is provided by novelist/essayist John Edgar Wideman, twice winner of the PEN/Faulkner Award. In his highly personal book, *Brothers and Keepers*, Wideman introduces us to his younger brother, Robby, who is incarcerated for life for murder. While being interviewed for the book, Robby explains to his brother how his behavior prior to incarceration reflected both a need for self-definition and a protest:

*Me and trouble hooked up. See, it was a question of being somebody. Being my own person ... Love you all but wasn't room left for me. Had to figure out a new territory. I had to be a rebel. (p. 85).*

Ethically, based on CASSP Principles and other humanistic considerations also, it is difficult to reconcile being a helper if one is not committed to provide unconditional respect to youth. Such commitment should be differentiated from moments of frustration, when the adult may fall short. However, when this has occurred, an acknowledgment and an apology to the child become appropriate.

Validation of the child’s need for respect comes from many sources. For example, anthropologist Phillippe Bourgois, focusing on the Puerto Rican barrio in New York, came to realize that the function of drug-dealing may not be based primarily on economic profitability:

*...crack dealers ... are not driven solely by simple economic exigency. Like most humans on earth, in addition to material subsistence, they are also searching for dignity and fulfillment. In the Puerto Rican context this incorporates definitions of “respect” built around a personal concern for autonomy, self-assertion, and community ... (p. 324).*

For this reason, Bourgois entitles his book, *In Search of Respect*, and advocates for a social contact based on "the politics of mutual respect," which involves prevention and "establishing long-term relationships based on trust" (p. 13).

### **The Need to Differentiate Respect from “Being Soft”:**

Those who believe that the provision of unconditional respect to children who are defiant represents a "soft" response to their transgressions need to recognize the distinction between respect and accountability -- e.g., offering respect need not entail abandoning accountability. In fact, one can simultaneously offer respect and also hold a child accountable. Consider, for example, the atmosphere created at Harlem's Rheedlen School, as described by Geoffrey Canada. The school security staff are responsible for school safety, but they meet their responsibility in ways that also value the students:

*The young men and women who make up our security team really like the children and don't try to intimidate them. When there's a problem, they try to reason, but they are firm. They don't believe in using force or bad language, or in bending the rules (Fist Stick Knife Gun, 1995, p. 141).*

It is apparent that reasoning with children and avoiding bad language, intimidation, and unnecessary force—all manifestations of *respect* toward children—in no way results in a bending of the rules. The students at Rheedlen are still held *accountable* for their behavior. Respect for children at Rheedlen is not limited to just security staff, nor is it an impersonal process. Canada describes how male teachers and male support staff function at Rheedlen:

*... men holding children's hands, wiping their tears away, reading them stories ... (so that the children) grow up knowing how normal it is for men to show concern, love, and tenderness for children. (Reaching Up for Manhood, p. 52).*

Unconditional respect for children, therefore, does not entail a lack of either expectations or consequences. A lack of expectations—as, for example, when adults mistakenly assume that children have no useful ideas to contribute to their home, school, or community and disregard their comments—is in fact, disrespectful, and is also inconsistent with prosocial outcomes. Similarly, failure to apply consequences when rules or expectations have been violated is disrespectful to the child, and is also inconsistent with prosocial outcomes. Thus, contrary to the ideas of some, both expectations and consequences are *essential aspects* of unconditional respect, rather than elements overlooked or sacrificed by the commitment to respect.

Another misconception is that unconditional respect means that a child can never be challenged. On the contrary, a respectful relationship allows for, even demands, challenge at certain times, so long as the challenge is offered constructively. Failing to challenge a child to do better, when indicated, is in fact disrespectful. What is essential is that the challenge—whether verbal or non-verbal, direct or indirect, serious or humorous—upholds the dignity of the child.

### **Conclusion:**

In working with children who are angry, defiant, and violent, the goal is not merely to coerce short-term behavioral compliance, nor to require that anger or rage be suppressed. What is essential is that the child experience him/herself treated consistently and respectfully, supported while held to clear standards, given reasonable consequences when indicated, and—perhaps most importantly—listened to

and encouraged to use words constructively. In this way, the child's code becomes known and eventually unnecessary, and prosocial behaviors become internalized.

To fully understand the concept of unconditional respect, one must appreciate that respect involves a way of viewing, being with, and responding to another person. Respect does not require blindness to violations of rules and limits. Similarly, respect does not require silence instead of challenge and tactful confrontation, when appropriate. Respect involves using the relationship to help the child overcome a specific dilemma or limitation, in a manner that models prosocial behavior and that promotes trust.

In the final analysis, respect entails a readiness to offer realistic hopefulness to the child, to recognize strengths, and to avoid the temptation to give up, when the going gets rough. To accomplish these lofty goals, it is important that adults cultivate both self-awareness and self-control, since working with any child produces frustration.

In discussing the needs of young males, Geoffrey Canada offers a clear perspective on the need for realistic hopefulness that I find relevant to both genders:

We ... have to make sure that there are always... people in a boy's life who haven't given up on him -- a family member, a teacher, or a mentor. This doesn't mean that we suddenly become pushovers, that we allow boys to escape unpunished or undisciplined after wrongful acts. It does mean that we always give them the message of salvation and forgiveness with our chastisements. It is important that even when we are at our wits' end we don't say things like, 'There's no hope for you' or 'I can tell you'll never change.' We need to say ... 'I know you can change.' (Reaching Up for Manhood, 1998, p. 103).

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## TIPS FOR THE PSYCHIATRIST IN WORKING WITH THE TREATMENT TEAM

1. *The psychiatrist as collaborating team member:* Remember that the goal is to become a part of, and to collaborate with, the treatment team, because the child's progress is best promoted through a unified, cohesive effort.
  - a. Find out name(s), roles, and telephone numbers of the child's treatment team members.
  - b. Obtain confidentiality waivers, so that reciprocal communication can occur.
  - c. Talk with, or meet face-to-face, the child's primary therapist. Encourage the therapist's participation at medication visits.
  - d. Indicate the nature of clinical information that would be helpful to you.
  - e. Share your impressions with the therapist or point person of the team.
2. *The psychiatrist as participant at team meetings:* Participate in interagency team meetings (ITMs) and treatment team meetings, whenever possible—in person, or by teleconference.
  - a. Assist the team in clarifying the child's diagnosis.
  - b. Assist the team in identifying key issues.
  - c. Assist the team in developing useful hypotheses.
  - d. Be available as consultant to the child and family.
3. *The psychiatrist as consultant regarding psychotropic medication:* Psychotropic medication does not belong exclusively to the psychiatrist, but is a team issue, as with other clinical issues:
  - a. Make sure that the child's psychotropic medication history, current medications with dosages, recent medication changes, blood levels (with explanation of desired level), and rationale for the use of medication are all known to the team.
  - b. Encourage the team to discuss and review medication-related issues, and to convey the results to you.
  - c. Make use of the team's support, when a child or family member is reluctant to agree to the use of psychotropic medication.

- d. Ask the primary therapist or other designated point person to give out and collect medication rating forms from teachers or parents, as needed.
- e. Convey your recognition that psychotropic medication is not usually a stand-alone treatment for SED, and needs to be used in conjunction with comprehensive treatment.
- f. Make use of opportunities to educate non-physician team members about psychotropic medication and its appropriate use, whenever possible. Use handouts, as appropriate.
- g. Remember, as consultant to the child, family, and other team members, to be responsive to questions and concerns, as they arise. Patience and availability are essential.

## ENGAGING MINORITY CHILDREN AND ADOLESCENTS THROUGH RESPECT

*Respect involves an attitude of interpersonal acceptance by the helper, and also a way of communicating that acceptance so that the child or family experiences it directly. Respect is a precondition of therapy with all populations, and is especially important in working with children and adolescents from minority populations where prior disenfranchisement may have given rise to reality-based caution. The following represent some of the ways that mental health professionals and others can engage minority children and adolescents through respect.*

1. Be a real and genuine person.
2. Be an active listener.
3. Be curious and ask questions.
4. Search for, and identify, competence and strengths.
5. Offer leadership and realistic hopefulness, where appropriate.
6. Acknowledge limitations.
7. Avoid power struggles, and help the child save face, when possible.
8. Use humor, when appropriate.
9. Recognize the importance of community ties and spirituality.
10. Consider symptoms from a cultural as well as a clinical perspective.
11. Work actively with the family and extended family.
12. Work with the treatment team, and avoid trying to do it all by yourself.
13. Use music, poetry, movies, commonly shared interests, and other culturally-based resources to forge a bond.
14. Be ready to discuss race and ethnicity within the therapeutic relationship.
15. Remember that trust develops slowly over time, so don't get discouraged or give up.

## POTENTIAL PITFALLS IN WORKING WITH MINORITY POPULATIONS

1. *The myth of color blindness:* Race does matter, and efforts to ignore it place unnecessary burdens on the developing therapeutic relationship. Issues of race and ethnicity represent critical realities to the child and family, and need to be acknowledge and addressed in some manner.
2. *Cultural misinformation:* Cultural generalizations can create preconceptions that mislead the clinician, such as that the actual, individualized beliefs and practices of the child and family are not understood. Recognizing cultural variations is a critical aspect of cultural competence.
3. *Inappropriate statements of support:* Listening and asking the client questions are more credible than such stock responses as, “I know what you’re going through.” Such statements lessen the credibility of the helper.
4. *Devaluing spirituality and family belief systems:* Typically, spirituality is a foundational support for minority populations. Statements that devalue spirituality or other pivotal cultural beliefs create alienation and probable client withdrawal.
5. *Taking it personally:* Interpersonal caution by clients may be culturally based, and may also be the result of reality-based, negative experiences. The clinician needs to appreciate that even a strong therapeutic bond does not completely override ethnically or racially based humiliations from the past. Caution is not necessarily rejection, and should not be taken personally.
6. *Failing to identify, and work with, the “real family”:* The “family” in many minority populations crosses over many generations, and includes more than nuclear family members and even blood relatives. The clinician who defines “family” conventionally or based on who initially attends sessions may be missing important aspects of the family reality.
7. *Unwillingness or inability to use feedback:* No clinician can be expected to always “get it right,” “say it correctly,” or avoid an occasional cultural faux pas. Fortunately, there is usually opportunity to reverse such miscalculations, but only if the clinician can recognize and use the (often nonverbal) feedback.
8. *Fear of talking about the therapy:* Due in part to the power imbalance between client and clinician, the client may not verbalize dissatisfactions with therapy. Unless the clinician is able to recognize signs of client discontent and bring the subject up, treatment may continue to falter and/or end prematurely.

## AN EFFECTIVE INTERAGENCY TEAM MEETING

1. Functions of the interagency team meeting:
  - a. A mechanism for child-driven, family-focused treatment.
  - b. A mechanism for individualization and positive envisioning.
  - c. A mechanism to integrate prescriber expertise with multi-system participation.
  - d. Within public sector managed care: a mechanism to incorporate the BH-MCO into the child-centered, family-focused approach consistent with CASSP Principles.
2. Desired outcomes of the interagency team meeting:
  - a. Achieving *consensus*, based on *common understanding* and *common goals*.
  - b. Initiating and maintaining an ongoing process of *collaboration and change*—e.g., team committed to the child over time, not just to meet in order to obtain funding.
  - c. Implementing *practical, workable solutions* for the child, including integrated treatment and feasible sources of funding.
3. Prerequisites for an effective interagency team meeting:
  - a. *Cross-system familiarity*: From the top-down and the bottom-up, with expansion of the middle. Knowledge of the roles and mandates of others.
  - b. *Good will*: A readiness to share time and expertise, consider the child's needs, and offer the benefit of the doubt to team members.
  - c. *Preparation*: Creating a meeting context: recruiting participants; confirming participation; sending meeting notices; preparing the child and family.
  - d. *Meeting protocol and methodology*: Need for a specific protocol for the meeting, so that everyone is oriented to the process and time is used effectively. Need for a designated team facilitator, to ensure that essential processes—including envisioning—occur.
  - e. *Follow-up implementation and monitoring*: Designated person takes, then distributes, meeting notes; clarity regarding specific tasks of each participant following the meeting; establishing mechanism for information exchange; setting next meeting date.

## MAKING INTERAGENCY TEAM MEETINGS EFFECTIVE

### Introduction:

*"Interagency team meetings are a waste of time."* Unfortunately, this comment is made too often by participants of interagency team meetings (ITM) for children, in both Fee-for-Service and managed care counties. When ITMs are not productive or empowering, they cannot serve as a catalyst for the sustained, individualized change process necessary to benefit children with serious emotional disturbance (SED) and their family. Many such children are at risk of out-of-home placement, entry into juvenile justice, or other negative outcomes. Within Pennsylvania service programs that seek to be consistent with a wraparound approach to treatment (*wraparound* refers to a collaborative, respectful approach to children and families that endeavors to help the child remain in the community by individualizing treatment and working in partnership with family and other involved systems, *not* to specific services such as Mobile Therapy and Therapeutic Staff Support), the interagency team has essential functions. The interagency team, through its formal meetings and its follow-up activities, is expected to play a key role in planning, implementing, and monitoring the child's treatment. When an ITM—especially the initial one—is ineffective, it is likely that the treatment to follow will also be ineffective.

Given the centrality of the ITM to the entire wraparound process, reports that many ITM participants regard it as ineffective needs to be addressed. This paper therefore addresses the following questions:

1. What is the intended role of the ITM in the system of care for children with SED?
2. What are possible reasons that the ITM is sometimes ineffective?
3. What are useful assumptions about an effective ITM?
4. What is a potential ITM protocol, consistent with Pennsylvania's system of care?

### The Intended Role of the ITM in Pennsylvania:

From a regulatory standpoint in Pennsylvania, the psychiatric/psychological evaluation, the ITM with its signed signature sheet, the service plan generated, and a completed Plan of Care Summary are all preconditions for authorization of Behavioral Health Rehabilitation Services (BHRS) or mental health residential treatment (RTF). Technically, the prescriber's evaluation represents the formal service request, but the input of the ITM is intended to validate or modify these recommendations, with a feedback loop back to the prescriber if there is disagreement.

The ITM has more than regulatory relevance, however. It embodies CASSP Principles in action. For example, the ITM provides a forum in which the child's unique needs can be addressed and the family's and child's voice heard (CASSP Principles #1 and 2: child-centered and family-focused). By drawing on the contributions of individuals with multiple perspectives who know the child, the ITM can enable different mandates and interests to be reconciled and a unified approach, with a single plan, developed (CASSP Principles #4: multi-system). In addition, the team draws upon natural supports and community resource persons (CASSP Principles #3 and 5: community-based and cultural competence). The clinical focus of the team plan is to help the child remain at home and in the community whenever possible, and to promote self-sufficiency as part of treatment (CASSP Principles #6: least restrictive/least intrusive).

The interagency team in Pennsylvania can be viewed as part of a system of checks and balances, not unlike the tripartite structure of the federal government (executive, legislative, and judicial branches). The formal evaluation brings in the expertise of a highly trained professional, a child psychiatrist or licensed psychologist, to assist in treatment planning. The evaluation, when comprehensive and thoughtful, offers the interagency team basic information about child and family, including an overview of the child in multiple life domains, and serves an important clinical triage function: that is, children in need of psychiatric inpatient hospitalization or crisis intervention are referred for these services immediately, as are children with acute drug intoxications or physical health conditions that may mimic SED. The evaluation offers specific treatment recommendations, including the prescription of specific professional service(s). The interagency team, for its part, includes a variety of individuals with expertise. Its most distinctive function, however, is to provide a unique mechanism for family and community participation in the child's treatment. Ultimately, the child's needs can be holistically addressed through the integrated efforts of prescriber and team.

For critics of the ITM process, the above description may sound fanciful. To be sure, the above outcomes are achieved only if there is communication and coordination within the larger system and commitment within the interagency team. While such processes may be elusive, the ITM offers a structure for the potential attainment of unity among all involved stakeholders. Viewed historically, earlier approaches to children's treatment were intrinsically limited in structure and scope. The account that follows is necessarily abbreviated, and is intended only to convey a context for the historical and pragmatic importance of the ITM:

1. Prior to the 1960s, there was limited overall attention to the needs of children, although there was a child guidance movement that had begun and been sustained from many decades earlier. The treatment of children was primarily individual, with very limited if any participation by parents. In some cases, the etiology of the child's disorder was seen as coming from the parents (e.g., parent-blaming).
2. With the development of family therapy in the 1960s and 1970s, the family was incorporated into the treatment process, sometimes but not always collaboratively. With some exceptions, the external environment was excluded.
3. An emerging ecosystemic approach in the late 1970s and early 1980s, building on family therapy and systems concepts, then began to address relevant external influences on the child and family such as school, child protective services, juvenile justice, etc. Typically, however, this approach involved serial interventions with external systems rather than a comprehensive multi-system gathering, so that treatment fragmentation and disagreement among systems were not satisfactorily addressed. In addition, there often was an absence of attention to natural supports as part of treatment.
4. With the development of CASSP and systems of care concepts—which occurred not in academe but in real world communities as an outgrowth of Ira Lourie's efforts at the National Institute of Mental Health in the early 1980s—the practice of bringing together all individuals and systems involved with the child (including natural supports) developed. This process, when effectively executed, offers the possibility of collaboration and unity among involved systems and individuals, thereby providing the greatest likelihood of genuine help for children with SED and their families.

### **Possible Reasons that the ITM is Sometimes Ineffective:**

A cynical point of view holds that the ITM is ineffective because the real agenda is not treatment planning per se but rather obtaining funds for services (for example, by providers) and containing cost (for example, by managed care). The ITM, it is argued, does not create a uniquely positive experience for child and family nor promote a multi-faceted understanding of the child's strengths and needs, but instead "cuts to the chase"—seeking to obtain or limit services. Given such limitations, it is argued, it comes as no surprise that services, once authorized, do not actually meet the child's needs. Further, when the ITM fails to serve as a useful mechanism for team empowerment and individualized planning for the child and family, it may be viewed as merely a bureaucratic imposition that delays service access and delivery.

A different perspective, and one that is favored here, is that the desire to conduct an effective ITM is present but that the role of the ITM and/or its effective implementation is not fully understood. For example, a common misconception is that the ITM is another evaluation, this time conducted by a team rather than by a single prescriber. Another misconception involves the belief that good intentions, in the absence of a clearly defined meeting protocol, will enable an ITM to be successful. Another limitation, the result of the misguided desire to "get down to work" prematurely, may involve insufficient attention to team building, with little or no opportunity for team members to become familiar and comfortable with one another.

There may also be training issues involved, with need for additional training of case managers and others on effective approaches to meeting facilitation. There may also be a need for broader system-based training on how to participate constructively within an interagency team setting, since these skills are not necessarily intuitive or part of professional training. Such training would address the importance of, and techniques for, listening, respectful communication, consensus building, and adherence to a team meeting protocol such as the one offered later in this paper.

At the same time that there is frequent verbalization of dissatisfaction with the ITM process, Delaware County's Family Satisfaction Team has developed, administered, and tabulated a parent satisfaction questionnaire, entitled "Parent's Opinion on the Interagency Team Meeting Process." This questionnaire is given to parents following the completion of an ITM for children with SED in Delaware County. Based on the first 50 surveys received by the Family Satisfaction Team during 1998, findings included the following:

1. Families indicated that they were informed about the ITM process, 86% of the time.
2. Families indicated that they felt comfortable during the meeting, 96% of the time.
3. The quality of the assessment and service plan was seen as positive, 84% of the time.
4. The accessibility of the meeting was seen as positive, 84% of the time.

These positive results appear to be inconsistent with ITM dissatisfaction as verbalized elsewhere in Pennsylvania. How can these findings be reconciled with identified concerns about ITMs? While no definitive answer can be provided, the following comments are offered:

1. The survey reflects the positive effect of a greater-than-usual commitment on the part of the county and its ITMs to inform families about the purpose and functioning of the interagency team meeting and to address family needs. To the extent that this is the case, the county's efforts should be better understood and emulated.
2. The awareness by all ITM participants that family satisfaction is being routinely surveyed helps to focus participants and promotes more conscientious implementation of the ITM.

3. The instrument in question measures family satisfaction but not provider satisfaction. Much of the dissatisfaction with the ITM comes from providers, and this dimension is not being measured.
4. Even though the ITM is viewed positively by parents in Delaware County, this does not imply that the ITM cannot be further improved through clarification of its essential components and the routine use of a standard meeting protocol.

Thus far, we have seen that there is concern on the part of some children's system stakeholders about the effectiveness of the ITM as commonly practiced, but that one county that has taken the initiative to develop a satisfaction questionnaire and tabulate its findings has had promising results. There is therefore ample reason to believe that, with greater understanding about the purpose of the ITM and the availability of a tool or protocol with which to conduct it, the ITM can serve the helpful function for which it is intended, within the children's system of care. We now consider some useful assumptions about an effective ITM. Then we offer one potential ITM protocol that is consistent with Pennsylvania's system of care.

#### **Useful Assumptions About An Effective ITM:**

The following are useful assumptions that increase the likelihood that an ITM will be effective in meeting the needs of the child with SED:

1. *There are two principal goals of an ITM to be kept in mind at all times.*

An effective ITM has two principal goals that set into motion an ongoing process to address the unique needs of the child and family. These goals are: a) to create a context for restoring hope to the child and family (referred to by Jerome Frank as "remoralization," in *Persuasion and Healing: A Comparative Study of Psychotherapy*) and b) to promote constructive, collaborative treatment planning to benefit the child and family. The unfolding ITM needs to be consistent with these two goals.

2. *An ITM is not another psychiatric or psychological evaluation:*

In Pennsylvania, the ITM occurs after a formal evaluation has already occurred and basic information gathered. This information should be available to the team. Beyond that, every effort should be made to obtain the participation of the prescriber in the meeting. Ideally, this occurs face-to-face. If this is not feasible, then telephone participation is preferable to none at all.

In order to avoid being "just one more meeting" that exacerbates feelings of futility, the ITM should not begin with another recitation of "what's wrong" with the child or family or a litany of the most pressing problems. Similarly, the meeting need not elaborate on every past service failure. As will be discussed in detail later, there are specific guidelines that can structure the ITM and increase the likelihood that it will be helpful to the child and family.

3. *It takes time to accomplish the work of an effective ITM:*

While it is laudable to try to prevent an ITM from being protracted, it is also important to be realistic about time expectations. In most instances, an ITM cannot be completed in a single hour. Scheduling just one hour for an ITM may place pressure on the team. Such pressure may result in a hurried rather than exploratory tone, with participants being interrupted and cut off. Rather than achieving a genuine consensus, the team may end up with a "consensus of convenience" in which participants make

agreements under pressure just so the meeting can end. It is unlikely that such agreements will be enduring or effective.

Although an ITM requires multiple participant hours and may be logistically difficult to schedule, it is appropriate to consider the probable time that would be required in its absence. Serial meetings with each involved system would ultimately require considerably more time. In addition, as discussed earlier, such a fragmented approach would provide no forum or mechanism for all involved parties to share relevant information and to resolve disagreements.

Most likely, any ITM not guided by a commonly shared meeting protocol will be perceived by participants as too long. But even when an appropriate protocol is used, sufficient time is needed to implement the protocol constructively rather than just “knocking it off.”

4. *If the appropriate stakeholders are not present, informed and meaningful decisions cannot be made:*

Consider the following situation:

A 16-year-old is behaving inappropriately in the school setting, fighting with other children and refusing to do work. This same child has been in frequent conflict with his stepfather and stepbrothers at home and violates curfew and other home rules. As a result, the child’s mother is now questioning whether or not the child can remain at home and in the community.

It is possible that the outcome of the ITM will vary, depending on who attends the meeting. If the ITM is attended by just the typical cast of representatives—a guidance counselor or primary teacher, the child’s mother, involved behavioral health staff, the case manager, and a county representative—the profile of the child that emerges might well reinforce only his oppositional and combative side. If, however, based on careful information-gathering prior to the meeting, the child’s school art teacher is invited to the meeting, another facet of the child might be disclosed—that he is very artistic, uses art for self-expression, and has a close, respectful relationship with this individual.

Similarly, careful information gathering about the child’s natural supports might result in the identification and subsequent participation of a community recreation worker who also has seen the more caring and respectful side of the child.

Such additional voices at an ITM can make the difference between a comprehensive understanding of an acting out or at-risk child and a superficial one, and between use of a strengths-based approach to decision-making and a more traditional deficit-oriented approach. At an ITM attended by all relevant parties, broad-based information can be shared, including elusive information about a child’s less frequently displayed vulnerable side. This additional perspective might catalyze an otherwise overlooked approach that results in a more creative, less restrictive outcome for the child and family. Through information-sharing, respectful exploration of disagreements, and consensus building, a unified direction for treatment becomes possible that maximizes services and resources rather than fragmenting them.

In pursuit of comprehensive representation at the ITM, the child’s parents should be encouraged to consider whom they would like to invite to support them and the child. Professionals should appreciate that families will not automatically understand that they can invite community support persons to an ITM unless they are informed of this option and encouraged to do so. In addition, as regards family and extended family participation, Nancy Boyd Franklin has pointed out that in African American families, the most influential family member(s) may not come to formal meetings and may need to be identified

and recruited. She states, “Many Black families present at clinics as they feel clinicians expect them to appear...This is where the therapist’s work begins (*Black Families in Therapy: A Multisystems Approach*, New York: Guilford, 1989, p. 152).

As regards the participation of the formal child-serving systems, all actively involved representatives of such systems should participate in a child’s ITM. An exception may involve the participation of school representatives, if the parents object and the child is not expected to receive mental health services in the school. Another possibility is that the family desires limited participation by a particular system representative. This situation may arise when the family wants the school to participate but prefers that school staff not have extensive information about home events. In this situation, it may be appropriate, through a prior-arranged process, to invite the school representative(s) to “visit” with the rest of the team to provide information about the child in the school setting sometime at the beginning of the meeting and then leave.

An effective and richly-attended ITM—with a diversity of participants beginning with child and immediate family and drawing from extended family and community, child-serving system representatives, and school staff—does not just happen. Such a meeting requires preparatory discussions with the family, identification of desired participants, active recruitment, written invitations, and follow-up telephone calls, with clarity as to who is responsible for each task.

5. *Family members need to be oriented and prepared for an initial ITM:*

Even when a structured meeting protocol is used, the first ITM may be overwhelming for the child and family. Many people are sitting around the table, some of whom may never have never previously met. In addition, the meeting may elicit flashbacks for the family of earlier meetings in which the family may have been blamed or otherwise felt devalued. For the child, such an experience may lead to either withdrawal or belligerence.

It therefore is important that child and family be oriented and prepared for an initial ITM. This can be done by the case manager, the prescriber of services, the individual making the referral, and a family advocate. If the family understands that the goal of the meeting is to be strengths-based, anxiety may decrease considerably. The family should also be briefed on the protocol and its rationale, and assured that their active participation is valued and essential.

To be effective, an ITM needs to be guided by established ground-rules and stages. Such structure helps set a constructive tone to the process, ensure that key issues are addressed, and promote effective use of time. Since there is more than one effective meeting protocol, the primary issues are a) that there be a protocol and b) that an individual familiar with it be designated as the meeting facilitator. When this occurs, the meeting is likely to flow smoothly. The meeting facilitator may be the same individual who invites and recruits participants, or a different individual. The identification of this individual is best made prior to the start of the actual meeting. The meeting facilitator may be the case manager, a therapist or other mental health professional, a wraparound coordinator, a school counselor, or a family member. It is the responsibility of the meeting facilitator to start the meeting, explain the protocol, initiate introductions, and make other initial comments, as indicated. Lucille Eber indicates that an important goal of the ITM is to create “a blame-free environment” (La Grange Area Department of Special Education’s (LADSE) Wrap Project handout, 1/23/95). If the participants appear attentive and comfortable after the facilitator has begun the meeting, then the facilitator is accomplishing an essential first task.

6. *There are many possible meeting protocols. Most share certain core elements:*

Experienced practitioners of the wraparound philosophy follow protocols for the ITM that may differ in some respects, and there is no single correct way to conduct these meetings. However, most ITM protocols share certain core elements. Five of these core elements are described below:

a. *Early discussion of strengths:*

Following the initial team building stage of the ITM, substantive discussion of the child and family should begin with *strengths*, not with problems, concerns, limitations, or failures. The latter are all well-known and have likely demoralized the child and family already. Another meeting that begins with a focus on pathology is likely to reactivate feelings of pessimism and convince the child and family that this is just a new name for an old meeting.

At times, team members may be so frustrated that they feel a need to describe the child's problems right away. Although under exceptional circumstances this might be the best option, often the prior orientation of members as to the goals and phases of the ITM along with the brief review of this at the beginning of the meeting is sufficient to engage even a frustrated participant in the process.

b. *Concern with child in multiple life domains:*

Regardless of the child's specific presenting concerns, the interagency team is interested in the whole child, understood in multiple life contexts (also known as life domains) and also within a developmental framework. Therefore, a treatment plan that only addresses specific problematic behaviors of the child without also promoting the child's attainment of age-appropriate functioning is not consistent with a wraparound approach.

There is no single "correct" delineation of life domains. In addition, since it may not be feasible to address every conceivable life domain of a child at every moment, the choice of life domains to address—and the specific goals within these life domains—are based on a prioritizing of identified needs. VanDenBerg and Grealish define a life domain as "those aspects of life in which almost all humans experience need on a day by day basis" (*Wraparound Process: Training Manual*, 1998, p. 2). The authors then identify "at least the following":

- Spiritual;
- Family;
- Community;
- Friends/Social;
- Health;
- Emotional;
- Legal;
- Work;
- Educational;
- Safety;
- Cultural;
- Others.

Elsewhere, VanDenBerg identifies a separate "Residential" life domain. "Family" is more explicitly defined as "Family or Surrogate Family." Other differences from the above formulation include the labeling of "Health" instead as "Medical" and subsuming the separate domains of "Work" and

“Educational” into “Educational and/or Vocational.” In addition, although not identified here by VanDenBerg, a team may want to identify and use a “Leisure/Recreation” domain.

Lourie and Isaacs, in contrast, provide a more abbreviated list:

- Mental Health;
- Education;
- Family;
- Health Care;
- Community.

The key point is that an appropriate group of life domains be addressed, to ensure that each child is considered comprehensively, not just in terms of behaviors, symptoms, and disorders. When a child is considered comprehensively, information comes directly from the child and family through the psychiatric or psychological interview and the ITM, not solely through written information and the judgment of professionals. Within a specific treatment plan, life domains can be listed in order of relative importance. For example, when there are concerns about safety and endangerment, it would be appropriate to start with the life domain that addresses “Safety.” For another child, this life domain might be omitted, or it could be listed with the comment, “No current issues.” It follows that a child’s written treatment plan should address multiple areas of the child’s normative functioning rather than simply break down specific behaviors of concern into components and regard the treatment of each component a new “goal.”

*c. Avoidance of premature discussion of services:*

Service decisions, when appropriately determined, are made near the end of the meeting, not at the outset. It is only after identifying strengths, goals, barriers, and available resources at hand that a team is ready to consider professional services. Premature discussion of services, even if well intentioned, bypasses the important information gathering and team building processes. Discussion of services should never serve to restrict consideration by the team of all relevant service options for a child. In addition, since the goal of the ITM is to promote genuine group inquiry, intimidating or disparaging statements should not be tolerated from any team member.

*d. Active participation by family:*

An effective ITM is one in which family members offer their points of view early in the process. Active and early family participation is important not only because of the family’s valuable perspectives offered but also as a way to signal to child and family that this meeting is for them and that they are equal participants in the process. In contrast, an ITM is problematic when parents sit silently during the meeting. If the parents and child do not offer their ideas spontaneously, it is the responsibility of the meeting facilitator to enlist their participation in a non-threatening manner.

The child, if at all possible and unless otherwise requested by the parents, should be encouraged to participate in the ITM. Some children may justifiably be deemed too young or developmentally inappropriate, but this decision should be considered carefully. Adolescents, based on their specific SED and their developmental stage, vary in their degree of participation and their attitude during the meeting. A strengths-based approach encourages the child’s participation and ensures that respect is unconditional, regardless of the child’s persona and responses during the meeting (see G. Hodas, “Working with children who are defiant: Unconditional respect comes first”).

*e. Inclusion of a group envisioning process:*

The reason for the formation of the interagency team and the convening of the ITM is the presence of a child with SED, functioning unsuccessfully in the current setting, who is at risk of endangerment and/or more restrictive placement and more intrusive treatment. This situation may occur for the child already receiving behavioral health services and for the child in need of such services. Given these compelling circumstances, it is not automatic or easy to begin a meeting with an identification of strengths as recommended above, or to resist the urge to identify a service to plug in, in an urgent effort to “fix” the problem. Similarly, situations involving crisis or impasse do not naturally lead to creative thinking about the future. Yet for an ITM to be effective and for wraparound to be successful, there needs to be a collective capacity of team members to move beyond the present in an imaginative manner, in order to envision desired outcomes.

From another perspective, we have suggested that the key goals of the ITM involve promoting remoralization and developing in a collaborative way a constructive plan for the child's future. Achieving these two goals also requires that participants move beyond the current impasse to identify a set of positive future outcomes—e.g., the same envisioning process is essential. Unfortunately, many ITMs as currently practiced—whether the consequence of a services preoccupation, time constraints, or lack of awareness—do not incorporate envisioning within the meeting. We see this as a major reason—if not the *major* reason—for the ineffectiveness of ITMs.

Envisioning as a process extends beyond the ITM. The professional's promotion of envisioning presupposes a recognition of the expertise of the parent and the validity of the child's own experience. It involves a readiness to listen and to share in developing a treatment built around the child and family reality. As Glenda Fine, founder of Parents Involved Network of Pennsylvania (PIN), pointed out many years ago in her discussion of parent-professional collaboration, “[Professionals] must be willing to ask parents what they need and want and what would be helpful to them.”

As with many aspects of sound practice, there is no single correct way of pursuing group envisioning. Lucille Eber has described one method which involves using a child who is “doing well”—this child is of similar age and cultural background as the client child—as the frame of reference (LADSE's Wrap Project, 1/23/95). This child who is doing well is designated a “typical” child, in an effort to avoid such potentially problematic terms as “normal” child. The team is asked to describe, with reference to various life domains, the ways in which this typical child is doing well. Once this discussion is completed and recorded, the next task involves brainstorming how the child of concern can become more like the typical child, in terms of identified competencies and accomplishments.

A different approach, which is favored here, involves using the client child as his/her own frame of reference. The team is asked to envision the child in one year, “doing well.” Beginning with parents and child, amplification of the child's “doing well” in the future is captured on the flip chart, with additional information about what this improvement positively looks like and how it positively affects the family. The task then becomes moving backwards from a positively identified future, in order to transform the problematic present.

Within Pennsylvania's Special Education system, envisioning is a central aspect of the interagency team meeting conducted for children under the Cordero court order (see “A resource guide for Individualized Educational Plan teams: An effective approach to meeting the needs of members of the Cordero Class,” June 1995). Based in part on person-centered planning, the identified meeting protocol begins with “Communicating Dreams/Vision.” This is followed by “Identifying Strengths,” which includes strengths of both child and family, and then “Identifying Natural Supports.” Following this

envisioning in conjunction with the identification of strengths and supports, “Barriers/Needs” are *then* identified, which leads to group “Brainstorming.” The end result of the Cordero interagency meeting, which is recommended for other students as well, is a set of consensually obtained “Interventions/Recommendations.” This plan is then implemented and subsequently evaluated, which over time results in goal modification, changes in implementation, and overall quality improvement.

7. *There is delineation of tasks and responsibilities, prior to the end of the meeting.*

Since the goal of the ITM is to identify a plan to help the child with SED and the family, it is essential that there be clarity about the tasks and responsibilities of various team members. There are many such tasks. For example, part of the role of the ITM is to determine the appropriateness of behavioral health services previously recommended by the prescriber. If the team concurs with these recommendations, no reconciliation effort is necessary. If the team has modified the prescriber’s recommendations and the prescriber has participated in the meeting and concurs, only a brief sign-off by the prescriber is needed. If the prescriber did not participate in the meeting, then a team representative (often the facilitator) needs to contact the prescriber, in order to identify the modification and its rationale. If the prescriber concurs, he or she signs off. If there is disagreement, this is processed further. [In Fee for Service, the team indicates its disagreement with prescriber in writing, in the submission to OMAP. In HealthChoices, a disagreement between prescriber and managed care gives rise to an Impartial Review referral to OMHSAS].

Other interagency tasks prior to ending the meeting include identifying the following:

- a. The individual responsible for completing the treatment plan with child and family.
- b. The individual responsible for completing the necessary paper work and submitting the formal request.
- c. The individual responsible for completing the meeting notes and distributing them.
- d. The individual responsible for contacting team members absent from the meeting, to keep them in the loop.
- e. The individual(s) responsible for contacting community agencies and natural supports identified during the meeting. [A comprehensive plan includes both professional services and natural supports].
- f. The individuals responsible during a crisis, and the nature of their specific roles.
- g. The individuals who will follow through with other identified tasks and interfaces.
- h. Finally, determination of the mechanism for communication between meetings, and clarity as to the next meeting.

8. *The ITM is conceptualized as just one function of a dynamic interagency team process:*

As indicated above, it is important that meeting notes are taken and distributed to team members and that efforts be made to keep missing team members in the loop. In addition, someone should be

responsible for keeping the flip chart sheets generated and bringing them to the next meeting. More advanced technology can also be used, such as an overhead projector or even computer projection techniques. Through use of any of these methods, there is continuity to the process and to planning and implementation. It is important to recognize that the interagency team *meeting*, although a formal prerequisite for BHRS and RTF service authorization, is just one aspect of an effective interagency *team*. A team that meets only to renew services and obtain funding, with no continuation of effort after each meeting, is not fulfilling its intended function. The need for the team to remain active throughout the child's entire treatment is reflected in John VanDenBerg's statement that "wraparound planning was formerly seen as an event, but should be seen instead as an initial step in a journey" (VanDenBerg and Grealish: *The Wraparound Process: Training Manual*, 1998, p. 64).

### **A Suggested ITM Protocol:**

It is important to remember that, before the formal ITM is convened, preparation is necessary. This includes determining, with the help of the family, who to invite to the meeting and actively recruiting these individuals as needed (always invite the behavioral managed care organization, in managed care counties). In addition, the child and family should be briefed as to the purpose and nature of the ITM, so that possible anxiety can be allayed and their participation maximized. It is important that the ITM be scheduled at a time convenient to the family. In some instances, when the meeting is at an agency site, transportation will need to be arranged. In other instances, it may be preferable to hold the meeting at the family's home, if this best meets the family need.

All interpersonal events of a helping nature, whether therapy, meetings, or other forms of interaction, ultimately depend on relationships and team building. In this way, a sense of trust and common purpose can eventually develop. Therefore, the first stage of an effective ITM promotes team building. From there the process continues until, by the end of the meeting, there is clarity regarding the overall direction of the plan, important next steps, and how they will be accomplished.

The proposed ITM to follow is based on the work of Eber and others and is modified to conform with Pennsylvania's system of care. The protocol consists of the following seven stages, which are then broken down into specific components:

#### *1. Stage 1: Initial Team Building:*

- a. Call to order by team facilitator.
- b. Introductory remarks by facilitator: Purpose of meeting is to bring together those who know and care about the child, in order to determine goals and develop a plan.
- c. Group introductions, with each participant asked to identify self, how they know the child, and what special contribution or expertise they bring to the meeting.  
  
Team members also sign in, providing contact information, with copies of this going to all team members.
- d. Review of basic meeting format and expectations:
  - 1) Begin with strengths, then identify goals, and eventually develop a practical plan. This requires sustained effort and commitment by all.

- 2) Offer respect and an opportunity to express oneself to every participant.
- 3) Assign responsibility to team members for following up with plan that is developed.

2. *Stage 2: Identification of Child and Family Strengths:*

- a. Parents and child are given first opportunity to contribute, but not forced to. Then everyone else contributes. Strengths can include those of child, family, community (natural supports), and formal agencies/systems involved with child.
- b. Each contribution is written on flip chart by facilitator.

3. *Stage 3: Envisioning:*

- a. Each participant is encouraged to imagine that it is one year later and “things have gone well” for child and family. Key questions: What is happening now? What does it look like?
- b. The facilitator records group responses, organized according to the relevant life domain, and notes the source of the contribution.
- c. The process stops when a picture emerges of child's positive future functioning and its effect on family. The facilitator clarifies comments when necessary and attempts to reconcile differences in vision.

4. *Stage 4: Goal-Setting:*

- a. Goals and methods typically emerge directly from the envisioned future. Additional elements can be added.
- b. If envisioning has gone well, parents can be asked, while still experiencing the envisioned future, “How did you get there?” Responses to this question may point the way for appropriate interventions in the present (objectives and methods). Alternatively, the question can be framed differently, in the present: “How can we get there?”

5. *Stage 5: Overcoming Barriers:*

- a. The team is asked what barriers must be overcome, to arrive at desired goals. These “barriers” include current concerns and limitations of child and situation.
- b. Methods of overcoming barriers include consideration of natural supports, role of child and family, professional services, referral to family advocacy resources, and possible psychotropic medication.

6. *Stage 6: Plan for Implementation:*

- a. Prioritizing of needs.

- b. Consensus on appropriate services and supports, drawing upon earlier psychiatric/psychological evaluation as point of reference.
  - c. Identification of other necessary elements (e.g., reconciliation with subscriber when necessary, others to contact, completion of the treatment plan, documents to complete and submit, additional evaluations to pursue if indicated, contingency crisis plan, etc.).
  - d. Identification of issues being deferred, and of issues lacking current consensus.
7. *Stage 7: Closure:*
- a. Assignment of tasks to implement above plan and to develop and distribute meeting notes.
  - b. In HealthChoices counties, feedback on next steps by managed care services manager.
  - c. Agreement as to mechanism for ongoing communication. Includes routine information, more urgent information, and a mechanism to reconvene the team in the event of unanticipated barriers to implementation of the plan.
  - d. Agreement regarding next ITM or treatment team meeting (smaller, clinical meeting), as indicated. Reconvening of meetings should not be predicated solely on need for service re-authorization.
  - e. Necessary signatures. Final comments. Anticipation of two key tasks of the team in the future: implementation and monitoring.

**Discussion of Protocol:**

The above meeting protocol is consistent with previously identified assumptions about an effective ITM. The ITM here is not another evaluation but rather a special opportunity to empower the family and team. Efforts have been made to prepare for the meeting and to engage a wide range of participants. Sufficient time has been allocated and there is recognition that an additional, probably smaller meeting may be needed in the near future. A meeting protocol is introduced and used, in order to create structure and the desired “blame-free environment.” The ITM focuses early on team building, strengths, and the engagement of family and child. There is holistic consideration of the child and avoidance of premature service discussion. Group envisioning is central to the process and involves using the child as his/her own frame of reference. When “barriers” are finally identified, this occurs within the context of a constructive meeting and is not disabling to team members. Finally, there is a mechanism for constructive closure and the assignment of follow up tasks for an active team.

### **Follow-Up ITMs:**

The above protocol can be used for follow-up ITMs, with modifications as appropriate. For example, group introductions may be omitted at the next meeting, if the participants are unchanged. If there are new participants at a subsequent ITM, however, then group introductions again become relevant. A brief orientation by the meeting facilitator is useful for every meeting, as a means of maintaining continuity and reminding team members of the goals and rules of the ITM. Review of the previously distributed written meeting summary, the child's current treatment plan, and flip chart sheets or overheads from the prior ITM may also promote continuity and serve as a useful point of entry for the new meeting.

While it may be tempting to focus on an immediate problem of the child, especially when the child has been faltering, a better approach involves reviewing progress first, consistent with the ITM protocol, in terms of previously identified goals and the envisioned future. Parents and the child should be encouraged to speak first, before turning to the providers and other participants. Since the child's progress is multiply determined, it is important to differentiate in the discussion between the child's overall progress (considered first) and the roles of specific providers (considered afterwards). The current status of the child should be reviewed in terms of both the current treatment plan and the broader, long-term envisioned outcomes obtained earlier. With this information available, the team can then determine appropriate modifications of services and supports, and conclude by assigning tasks, like before. In this way, the interagency team maintains continuity of purpose while also making modifications appropriate to the child's treatment and necessary for overall quality improvement. Over time as progress continues, efforts are made to augment natural supports and reduce professional services, as clinically appropriate.

### **Conclusion:**

The frequency of complaints about ITMs within the public sector system of care for children suggests that there is legitimacy to these concerns and a need to address the issue. At the same time, the findings within Delaware County suggest that when attention is focused on this important children's service mechanism, family satisfaction can be high. Conducting an effective ITM is a key responsibility of the interagency team, and the interagency team is an essential component of an individualized or wraparound approach for children with SED and their families. Without effective ITMs, the system of checks and balances is compromised, services may be accessed and continued inappropriately, and the important goals of individualized treatment and treatment monitoring may be seriously compromised. In addition, when ITMs are ineffective, frustration and even cynicism about the entire children's system can occur.

This paper has assumed that the problem with ITMs, to the extent that it exists, is one of incomplete understanding of the concept of the ITM and its effective implementation, rather than a lack of interest or commitment on the part of participants. We have considered some useful assumptions about the ITM and have offered a potentially effective meeting protocol. No protocol, however, will work in the absence of a commitment to allocate necessary time and a resolve to move beyond allegiances based only on the system or constituency represented by that individual. There is also need for ongoing efforts to help team members avoid the unwitting perpetuation of stigma against children with SED and their families. As suggested elsewhere (see G. Hodas, "The real impartial review: The interagency team meeting"), there also needs to be impartiality to one's externally defined role in favor of *partiality* toward meeting the needs of the child comprehensively and creatively. Such a mind-set may at times require the suspension of previous negative experiences in team meetings, and is best achieved by presuming the positive about team members (see G. Hodas, "Presuming the positive' as part of strengths-based treatment in working with children and families"), and seeking to develop a common mission.

Keeping one's "eyes on the prize" entails developing an approach to help the child and family over the short-term in a way that does not compromise long-term self-sufficiency. Hence, the need to combine professional services with a wide range of community supports, and to monitor progress carefully. Another important element of success involves avoiding blaming, whether blaming of the child, family, or the professional. Regarding the latter, Doreen Barkowitz and Wendy Luckenbill, family advocates in Pennsylvania, point out that "respect is a must for everyone," and advise parents to "forgive clinicians, teachers, and other professionals for not knowing how to give perfect services in an imperfect world—then work with them and your child to support the child in reaching his or her hopes and dreams."

The children's system of care in Pennsylvania and elsewhere is still in its early stages. There is continued need to listen and learn, to value collaboration, and to share ideas generously. There is also a need for service innovations and outcome-based research at all levels. Stakeholders can move to the next level by identifying critical aspects of effective children's behavioral health treatment, pursuing greater understanding, developing and disseminating treatment models, and basing practice and quality improvement on both family satisfaction and objective clinical outcomes. Systems improvement—and the imperative to meet the needs of individual children effectively—are too important to be based solely on anecdotes and good intentions.

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## THE REAL IMPARTIAL REVIEW The Interagency Team Meeting

As the initial and primary Impartial Reviewer of EPSDT mental health requests for the Department of Public Welfare since the inception of this quality assurance mechanism in 1992, I have now completed more than 400 written reports. The vast majority of these Impartial Reviews have involved requests for community-based EPSDT mental health services — also known as enhanced mental health services, "wraparound" services," and behavioral health rehabilitation services — from the Fee-for-Service system and from voluntary Medical Assistance managed care.

Requests for Impartial Review are generated either by Medical Assistance or voluntary managed care when medical necessity is questioned under any of the following circumstances:

1. Documentation of medical necessity — via psychiatric or psychological evaluation and/or treatment plan — is deemed inadequate.
2. Service requests appear inappropriate in type and/or intensity.
3. Treatment does not appear to be active, and/or there is concern that the child's needs are not being satisfactorily met (includes lack of implementation of CASSP Principles).
4. The interagency team has been unable to reach consensus regarding what constitutes medically necessary services for the child.

While I regard DPW's Impartial Review process as a vitally important component of Pennsylvania's system of care, I am also clear where the real impartial review should occur — within the setting of the interagency team meeting and under the ongoing auspices of the treatment team. It is essential that the direct participants in care develop a common understanding and a common vision of what a child needs and how to achieve it. As important as quality assurance oversight is, an interagency team that relies too often on case-specific resolutions at an administrative level removes decision-making from those at the local table who know the child best.

The phrase "impartial review" is a fitting description of the work of an effective interagency team. Participants from child-serving systems need to be impartial so that the needs of the child and family gain primacy over the specific needs of any agency or system. In this way, issues can be identified and responded to on the merits. In reality, an impartial review requires *partiality* — partiality in favor of the child and family and partiality in favor of the CASSP Principles. Such commitment is achieved when each participant is willing to identify him or herself primarily as a *team member* representing the needs of the child and family system rather than solely as a representative of an agency, system or constituency.

While some disagreements about a child's service needs are inevitable, and concerns about the adequacy of specific plans or documents can be expected to arise, I believe that these disputes can be minimized if certain ideas are kept in mind. The ten ideas below derive as much from common sense as from sophisticated mental health concepts:

1. ***"Discuss the child in context":***  
Children live in families and communities, and function in multiple life domains. Age, race, classroom grade and setting, family composition and relationships, interests and strengths,

community involvements and resources, etc. all need to inform the overall evaluation. Remember: You can't individualize *treatment* unless you first individualize *information*.

**2. "Tell the child's and family's story":**

The task of the mental health or other human service professional is, first, to listen to the story and then tell it. An effective story captures the essence of both the need and the opportunity. It is helpful to bear in mind that evaluations and treatment plans constitute clinical communications, not executive summaries. Evaluations should contain relevant details necessary to convey essential points.

**3. "Relate to and describe the child as a real person":**

Ask about and report the child's own thoughts, ideas and goals, and summarize the child's way of relating to the interviewer and other participating adults.

**4. "Make each treatment plan a real workplan":**

As a workplan, an effective treatment plan conveys the work to be done and indicates how it will get done. The treatment plan also carefully reviews prior goals and objectives. A comprehensive treatment plan identifies goals and objectives in more than two life domains so that treatment addresses the child developmentally. In these ways, a child's treatment plan becomes an instrument of accountability and a benchmark of progress.

**5. "Work with strengths":**

Understand the various components of strengths-based assessment — aspirations and goals, capacities and interests, coping skills, and relationships and organizational attachments — and acknowledge and support these areas of child and family competence.

**6. "Think CASSP":**

CASSP Principles are not a bureaucratic pronouncement but rather a set of clinically and ethically grounded service system principles that have evolved over the last ten years both in Pennsylvania and throughout the country. When they are implemented with commitment, children get better.

**7. "Listen, talk, compromise, and make adjustments as needed":**

Expect disagreements around the table, and expect also to compromise. No service decision should be so final that, if necessary, it cannot be revisited. When consensus is achieved, the team remains viable and is empowered. Persistent disagreements are neither empowering nor cost-effective, and can sabotage clinical progress as well.

**8. "Be creative":**

Creative clinical problem solving should be supported and is the essence of individualized treatment. Such an approach — for example, obtaining a YMCA membership for an isolated, inactive child — can also be highly cost-effective in the long run.

**9. "Don't just depend on professional services":**

Mental health services are generally time-limited. The family and community will remain. Draw actively on these resources, and help develop them when necessary, so that treatment promotes self-sufficiency.

**10. "The goal is treatment, not just services":**

It is important to appreciate that the goal of mental health is to offer treatment, not just to provide services. *Treatment* is a generic concept that incorporates appropriately selected professional services but goes beyond just services to include: team unity, a shared clinical formulation and game plan, use of community-based resources, and the promotion of self-sufficiency for the child and family. Our job is to provide quality treatment, not just services.

The next few years will go far in determining whether or not individualized care in Pennsylvania can remain viable, and whether children with serious emotional and behavioral disturbance will be found primarily in communities or in detention facilities and psychiatric institutions. The stakes are high but we have already developed substantial knowledge and expertise. It remains for local teams to recognize that achieving consensus is not just a prerequisite for service provision but also a significant determinant of quality care in its own right.

## PRINCIPLES OF EFFECTIVE HOME-BASED TREATMENT

1. *Information:* Strong front-end evaluation, carefully reviewed with other relevant documents, prior to direct involvement with the child and family.
2. *Connection:* A real, person-to-person connection, with integrity and appropriate boundaries.
3. *Orientation:* A therapist or worker who understands, and desires, home-based work.
4. *Systemic, Biopsychosocial Approach:* Concern with biological, psychological and social dimensions.
5. *Good Manners:* Appropriate behavior as a guest of the family, including respect and humility.
6. *Treatment Plan-Based:* A mutually established, goal-directed agenda, with clearly identified objectives and roles for participants.
7. *Collaboration:* Readiness to share decision-making, draw upon respective areas of participants' expertise, and use feedback constructively.
8. *Specific Intervention Method:* Therapy based on an established method of intervention, not just good intentions and spontaneity.
9. *Outcome Orientation:* Parameters of progress clearly identified and reflected, at least partially, in quantitative measures.
10. *Supervision:* A designated supervisor reviewing progress, ideally with all involved members of the clinical team. Interest in case-specific, systemic, and professional development areas.

## KEY CONCEPTS FOR HOME-BASED CLINICIANS AND WORKERS

1. *“Follow CASSP”*: Help transform CASSP from “treatment principles” to “principled treatment.”
2. *“Treatment, not just services”*: Services alone, without understanding and commitment, are not helpful.
3. *“Listen to, and tell, the story”*: Cannot treat something you don't understand.
4. *“Connect”*: Without genuine relationships, there is no treatment.
5. *“Build on strengths”*: Without recognition of strengths, treatment cannot be effective.
6. *“Be partial, and be impartial”*: Effective teaming requires all members to be partial to the child and impartial to the agency or system that they represent.
7. *“Ask the Alfie question”*: Ask yourself and the team, “What’s it all about?” This kind of overview promotes successful treatment.
8. *“Be a philosopher-king”*: Drawing upon both child and family input and one’s own expertise, the prescribing clinician should demonstrate strong clinical leadership, in offering treatment recommendations.
9. *“Treat the whole child”*: Treatment involves more than eliminating/reducing “bad behavior.”
10. *When in doubt, ask*: There is no shame in learning from others, whether about concerns, strengths, culture, or anything else.

## FBMHS ("FAMILY-BASED") VS. BHRSCA ("WRAPAROUND")

	<b>FBMHS</b>	<b>BHRSCA</b>
<b>Therapy Component</b>	Co-therapy team	One therapist
<b>Other Services</b>	FBMHS usually inclusive Includes MT & BSC functions Use of TSS on occasion Team an ongoing unit No separate CM	Possible BSC Possible TSS Team usually ad hoc Separate CM
<b>Indications</b>	Out-of-home diversion Step-down from placement	Out-of-home diversion Step-down from placement Other SED children
<b>Guiding Philosophy</b>	CASSP Principles	CASSP Principles
<b>Primary Focus</b>	The <i>family unit</i> , including child, siblings, and parents	The <i>child</i> , and parents in relation to child
<b>Primary Technique</b>	Systems therapy—Structural Family Therapy	Varies w/therapist
<b>Site of Services</b>	Home and community Specific site(s) based on need	Home , community, school Specific site(s) based on need
<b>Enrollment</b>	Voluntary only MA or non-MA	Voluntary only MA-only
<b>Coverage</b>	"24/7," by FBMHS program	CM and crisis intervention covers after-hours
<b>Funding</b>	Back-up/admin. time billable	Limited billing of admin. Time
<b>Supervision</b>	FBMHS director, of entire team	BHRSCA provider
<b>Minimum Training</b>	Cohesive 3 yr. Curriculum	Requirements of regulations No specific curriculum
<b>Special Uses</b>	More than 1 child in need Parents identify own problems Parents request FBMHS Multi-system involvement Failure of BHRSCA	Child at risk, moderate need Child needs TSS Specific Axis I Diagnoses
<b>Potential Pitfalls</b>	Under-focusing on child and his/her specific symptoms Aftercare transition	Over-focusing on the child's behaviors Limited therapy with family Service over-utilization

## SELECTED ETHICAL ISSUES FOR BEHAVIORAL HEALTH THERAPISTS AND WORKER (*Mental Health Professionals in All Settings and Therapeutic Staff, When Involved*)

1. *Reviewing available documents, prior to beginning direct service:* To ensure that you have the necessary information and background needed to provide individualized service.
2. *Establishing that the purpose of involvement is to be “of service” to the child and family:* To let the child and family know that you desire to be “of service” to them, according to their needs, since services are intended to benefit the child and family.
3. *Making a real connection:* To create a sense of “welcome,” and to convey to the child and family that they matter to you and are not just “another case.”
4. *Providing treatment consistent with the treatment plan:* The treatment plan identifies agreed upon goals, and defines appropriate roles and functions for practitioners. It should be followed, and then modified by the team, as needed.
5. *Communicating with other team members regularly:* With team-based treatment, the role of each practitioner includes the regular sharing of clinical information with other team members.
6. *Operating in a manner consistent with professional scope of practice, and with professional codes of ethics:* The professional code of ethics and defined scope of practice provides the first set of ethical standards for the practitioner.
7. *Operating in a manner consistent with CASSP Principles:* In Pennsylvania, CASSP Principles provide a second ethical standard for the practitioner.
8. *Operating in a manner consistent with the PA CASSP Training and Technical Assistance Institute’s “Guide to Professional Conduct”:* The Guide to Professional Conduct reflects important aspects of CASSP Principles in need of special articulation. It is essential that the practitioner understand and maintain client confidentiality; avoid dual relationships and maintain appropriate boundaries in working with clients; and deal with emotionally charged, challenging situations in a professional manner.
9. *Working with the family as partners:* This includes respecting family knowledge and expertise; listening and learning; supporting family participation in all phases of treatment; providing ongoing feedback, information and technical assistance; offering appropriate leadership and hopefulness; and other functions.
10. *Collaborating with the interagency team and treatment team:* As a person working directly with the child and family, your information and participation are indispensable to interagency and treatment team meetings.
11. *Writing respectful, accurate progress notes:* Progress notes should always respect the dignity of the client, and should convey actual progress observed.
12. *Obtaining regular supervision:* Unless otherwise specified in regulations, each practitioner should receive regular clinical supervision by a qualified supervisor.

## IMPLEMENTATION OF THERAPEUTIC STAFF SUPPORT Practical Approaches

### **Introduction:**

TSS is a mental health support service that, when medically necessary, is guided by the individualized behavioral health treatment plan for the child or adolescent, the primary clinician as designated by the interagency team and the TSS supervisor. The behavioral health treatment plan itself is a reflection of the interagency team process, and has been developed with the active participation of the child and parents or other caregivers. The TSS worker acts to support the implementation of the behavioral health treatment plan in support of the identified child and family goals.

Implementation of TSS may involve a variety of practical approaches, in support of commonly identified goals. In what follows, practical interventions are identified that enable the TSS worker to work toward the achievement of certain commonly identified treatment goals. *While, for purposes of training, a list of interventions is offered below, it must be understood that these interventions are to be used only in accordance with the child's specific treatment plan, as directed by the primary clinician and the TSS supervisor.*

### **Common Treatment Goals and Potential TSS Interventions:**

- 1. Obtaining information about the child's problematic behaviors, in order to determine the child's behavioral patterns.** The TSS worker records this information systematically, and conveys it to the primary clinician so that it can be incorporated into the treatment plan. The TSS worker may also share information with the parents and child, as determined by the primary clinician. Following are some examples of information to be obtained and documented:
  - Where problematic behaviors occur (e.g., at school, during recess, at home, during dinner, in the community, when with older peers);
  - Frequency of behavior;
  - Apparent precipitants;
  - Specific behavioral responses by child;
  - Duration of episodes;
  - Typical reactions and responses by others, and effect of these on the child;
  - Most effective interventions to interrupt cycle;
  - The child's own ways of maintaining control, problem-solving, and settling self;
  - The child's response to TSS worker during times of emotional upset, as compared to other times.

## **2. Reinforcing parental roles and responsibilities with the child:**

- TSS worker discusses, with parent, the plan for scheduled contact with the child that day.
- TSS worker obtains updated information from parent, about the child's functioning, since the last contact.
- TSS worker highlights and verbally reinforces cooperative, respectful, age-appropriate responses by the child toward the parents (e.g., "I was impressed with the way responded to your mother's request right away, and how you looked right at her when you spoke to her").
- TSS worker supports parental adherence to specific protocols developed by primary clinician, for use with the child (e.g., Stop and Think approaches, sticker calendars with specific tasks for the child, consistency in limit-setting).
- TSS worker offers positive statements to the child individually, at appropriate times, about his or her parents (e.g., "Did you notice how proud your dad looked when you showed him the terrific point sheet from school today?").
- TSS worker helps the child practice expressing him or herself to parents, using techniques as directed by the primary clinician in the treatment plan (e.g., "Do you really think your mother is going to listen to you if you yell at her like that? Why don't you try it again, more slowly and calmly?").

## **3. Helping the child integrate into an identified community activity:**

- TSS worker reviews with the child, prior to the specific activity, the nature of the activity to follow and likely expectations for that activity (e.g., "As you know, part of the reason that you're joining this team is to make friends and get along better with other kids. During the game, it may get intense, but that's no reason to lose your cool").
- TSS worker observes the child's interactions with agency staff and peers, in terms of:
  - Degree of attentiveness and responsiveness to the coach or other adult authorities;
  - Ability to follow specific rules;
  - Positive individual and team efforts by the child (e.g., the child approaches a peer and starts a conversation; the child hustles during tem play; the child offer encouragement to a teammate; the child passes the ball, rather than hogging it);
  - Responses to aggressive and/or inappropriate behavior by peers;
  - Degree of self-control.
- Based on systematic observation of the child's functioning, TSS actively supports the child's participation in the community and other setting. Specific individualized TSS responses may include the following:

-Nonverbal cues of support for child's positive responses (e.g., "thumbs up" or a clap of hand, when the child scores a basket, catches the football, or ignores an elbow by another peer during the game);

-Nonverbal cues for the child to change an immediate behavioral response (TSS worker points at forehead, to signify "stop and think," or points at wristwatch, to tell the child to "slow down and calm down");

-Taking the child aside momentarily, if necessary, to discuss the situation and to consider positive choices to be made;

-Discussion about the experience afterwards with the child and parents (e.g., To the child: "I was impressed with how focused you stayed during the game, and how you didn't let yourself get angry when that other guy started trash talking you." To parents: "Your son made good progress with his treatment plan today. Bill, do you want to tell them first, or should I start?").

#### **4. Helping the child improve interactional skills with peers:**

- TSS worker encourages the child to identify areas of interest, competence, and familiarity, which he/she can use in social conversations (e.g., "OK, Sue, we both know you have many interests and are an interesting person. What are some of the things you can talk about with your classmates at the party tomorrow?").
- TSS worker encourages the child to learn to ask question with peers, and to listen actively to responses;
- TSS worker encourages the child to practice use of social skills (e.g., "Can you remember that one of the best ways to start a conversation is to ask the other person a question? What kind of questions could you ask Tyrone?").
- TSS worker helps the child build confidence in preparing for social interactions through practice of conversations with TSS worker (e.g., TSS worker engages a quiet or shy child in a conversation about an area of interest to the child, then points out how well the child did; TSS worker discusses a child's recent interaction with a peer afterwards, and offers supportive feedback).

#### **5. Helping the child to de-escalate when angry.**

- TSS worker helps the child identify, even write down, specific trigger points for anger, as directed by primary clinician (e.g., "What was it that got you so angry? Do you think it had to do with his tone of voice, or what he said?").
- TSS worker helps the child identify the benefits of non-aggressive responses, and possible consequences of aggressive responses (e.g., "Do you realize that when you let Justin get you to lose your cool, you're giving him the power to control you? What can you do instead of punching him out?").

- TSS worker helps the child implement a specific protocol for decision-making/de-escalation (e.g., stop and think or others), if identified within treatment plan (e.g., “OK, Bill, this is what we’ve talked about. You’re starting to get ticked off. Remember what you’re supposed to do when this happens?”).
- TSS worker cues child nonverbally and indirectly, at sign of de-escalation, or uses simple verbal cue, as previously agreed upon (e.g., TSS worker points to forehead, to encourage the child to “stop and think,” or to wristwatch to encourage the child to calm down; TSS worker calls out to the child, “Remember RJ,” because RJ is a positive role model whom the child has identified as a verbal cue for when he is about to lose his temper).
- TSS worker reviews the de-escalation plan with adults in the setting where services are being provided (e.g. with parents in home, teacher in school, or coach in community activity) and with child, so that implementation is predictable and consistent for child and others.
- TSS worker uses time-out interventions, as needed and as previously determined by primary clinician and parents (e.g., “OK, Mrs. Williams. Charles is disrespecting you, and you’ve given him three chances, just like the treatment plan says. Do you think Charles needs time-out now?”).
- TSS uses verbal praise for the child when the child is showing self-control.
- TSS worker discusses the situation with the child, after a specific incident or near-incident;
- TSS worker encourages the child's keeping of a journal or diary, as directed by the therapist, for the child to record feelings or instances of positive coping.

**6. Promoting appropriate attitude and decision-making by the child:**

- TSS worker, building on earlier efforts by the primary clinician, helps the child identify positive role models within the family, neighborhood, or larger culture (e.g., “I really respect how hard your father and mother work to support you and your sister.” “You told your mobile therapist that you respect your family’s minister. What is it you like most about him?”).
- TSS worker offers ongoing positive feedback for positive choices by the child.
- TSS worker reminds the child of his or her previously identified personal goals, and of the importance of making good choices in order to achieve them (e.g., “You said that you want to get off probation. What do you think will happen if you hang out with those guys who are breaking into cars?” “What’s more important, getting money fast, no matter how you get it, or taking the time to earn it?”).

## TSS IN ACTION: THE TSS WORKER PROMOTING A SPECIFIC COMMUNITY INTEGRATION ACTIVITY (Basketball)

Bill West is a 15-year-old Caucasian male who is diagnosed with Oppositional Defiant Disorder and Intermittent Explosive Disorder. Bill lives with his mother, who is a single parent, and two younger brothers, with whom he is often in conflict. Because of his temper, poor home adaptation and social isolation with few friends, Bill is now receiving the services of a Mobile Therapist and TSS worker.

Among the goals on Bill's treatment plan are those of improving peer relations and becoming involved in community activities. As a result, Bill has joined a community basketball league that meets twice a week. In accordance with the treatment plan, the TSS worker accompanies Bill to the games and remains there to assist him as needed.

The following are some of the interventions of the TSS worker with Bill, before the first league game:

1. Before leaving to walk over to the basketball court with Bill, the TSS worker confirms with Ms. West the activity about to take place and the time of expected return.
2. During the walk, the TSS starts chatting with Bill, asking him if he has done his stretching yet, how he is feeling, etc. Then he reminds Bill that the activity to follow has many purposes. Enjoying basketball is one of them, but other goals include following the rules, getting along with the other kids, listening to the coach, and staying under control even if feeling angry. Bill acknowledges that all of these are his issues and that he does want to deal with them.
3. The TSS worker then reminds Bill that basketball is often an aggressive game. Guys are competing for rebounds and push each other, and they also try to take the ball away from one another. Will Bill be able to handle this, when it happens to him, or will he take it personally and explode? Bill nods to indicate that he understands what the TSS worker is saying.
4. The TSS worker asks Bill if it will be all right if he introduces himself to the coach, and explains why he is there. Bill agrees, so long as the TSS worker promises to do it privately. The TSS worker and Bill agree on a sign that the TSS worker—or Bill—can use if either feels a need to talk to the other or to get the other's attention. The TSS worker also asks Bill if he is ready to let his teammates know when they make a good play.
5. The TSS worker introduces himself to the coach, and Bill separately does the same. Bill starts out on the bench. When he gets into the game, his teammates do not throw him the

ball. The TSS worker can see that Bill is getting frustrated, but Bill signals that he's OK. When Bill gets his first rebound, he throws it out to a teammate, who passes it upcourt for a score. Bill smiles slightly.

6. Later on, Bill grabs a rebound and is clobbered by a member of the other team. The TSS worker notices Bill start to clench his fists. However, Bill looks over, the TSS worker signals Bill to cool off, and Bill goes up the court without throwing a punch.
7. On the walk home after the game, the TSS worker congratulates Bill. Bill is more talkative than usual. He talks about how he really wanted to beat up that other player, but somehow was able to control himself. Maybe it was because he had seen the same rough play with others, not just him. Maybe there were also other reasons, Bill isn't sure. But he feels pretty good now.
8. Upon returning home, the TSS worker asks Bill to tell his mother about the activity. When Bill is finished, the TSS worker adds his impressions and lets Ms. West know that Bill made meaningful progress that day.

Many of the same steps are repeated each time Bill and the TSS worker go to the league basketball games. The TSS worker is skillful in reminding Bill about his treatment goals without sounding preachy, and also encourages Bill to enjoy the basketball activity directly.

## THERAPEUTIC STAFF SUPPORT: A MENTAL HEALTH SERVICE, NOT A BIG BROTHER/BIG SISTER

### **The Big Brother and Big Sister**

A Big Brother/Big Sister (BB/BS) is a volunteer individual who offers a positive, personal relationship to a child, as part of a community service. The relationship is non-professional, and does not involve use of a behavioral health treatment plan with goals and objectives. The BB/BS is a role model for the child, and also commonly serves as an informal mentor. It may be appropriate for the child to regard the BB/BS as primarily a “friend,” and the relationship may continue for many years, even after the community service is no longer being formally provided. The foundation of the BB/BS’s relationship with the child involves such core elements as respect, caring, altruism, trustworthiness, reliability, self-control, and a capacity to listen and provide support.

While the BB/BS relationship is sanctioned by the child's family, the primary beneficiary is the child. The BB/BS meets with the child at designated times, in settings arranged in advance that are acceptable to the child and family. It may be appropriate for a BR/BS to take the child to his/her own home, or to introduce the child to family, friends, and co-workers. On occasion, the BB/BS may, in the manner of a family friend, give the child gifts. As a non-professional, the BB/BS may make personal disclosures to the child, so long as they are age-appropriate for the child and socially appropriate. It is expected that a BB/BS, as a sanctioned adult role model for the child, will conduct him or herself in a manner that is ethical and lawful, and consistent with socially accepted standards. Finally, an effective BB/BS is familiar with, and respectful of, the child’s and family’s cultural beliefs and practices.

### **The TSS Worker: Similarities with the Big Brother and Big Sister**

For the TSS worker, there are some important similarities with the role of the BB/BS, and important differences. Similarities include the need for the TSS worker, like the BB/BS, to embody core personal characteristics which, taken as a whole, comprise integrity. These characteristics are respect, caring, altruism, trustworthiness, reliability, self-control, and a capacity to listen to and support others. The TSS worker’s relationship with the child, like that of the BB/BS, is sanctioned by the child’s family. The TSS worker meets with the child at designated times and in settings arranged in advance, acceptable to all parties. As with the BB/BS, just by working with the child, the TSS worker becomes a role model for that child (although this is not the primary rationale for the service). The TSS worker’s effectiveness, like that of BB/BS, rests fundamentally on that individual’s ability to establish a sense of trust with the child. As with the BB/BS, the TSS worker’s conduct must be ethical and legal, consistent with socially acceptable standards, and respectful of the child’s and family’s culture.

### **The TSS Worker: Differences from the Big Brother and Big Sister**

Differences between the TSS worker and the BB/BS begin with the fact that the BB/BS agency offers the child a volunteer, community-based relationship, while the behavioral health provider offers TSS as a reimbursable, contracted service. Unlike the BB/BS, the TSS worker is part of a professional behavioral health team. The TSS worker is obliged to follow specific guidelines for professional conduct, some of which do not apply to the non-professional BB/BS. By serving a professional role, the TSS worker is expected to be more closely supervised than a volunteer BB/BS. While the TSS worker, through his or her presence, becomes in some respects a role model for the child, there are other, specific behavioral health roles that are defined by the treatment team and identified in the child's treatment plan.

These behavioral health roles constitute the essence of the TSS service, without which it would not be medically necessary.

Some children, it must be acknowledged, loosely regard the TSS worker as a “friend,” but such designation is based on the child’s awareness of the TSS worker’s interest and concern, not the result of the TSS worker’s sharing his or her personal life with the child. Thus, self-disclosure on the part of the TSS worker is much more limited than with a BB/BS, and is subject to a supervisor’s review and approval. Similarly, the TSS worker does not give gifts to the child, except under highly unusual circumstances (e.g., possibly as part of a planned termination). Gift-giving, like personal disclosure, is subject to the review and approval of the TSS supervisor.

The beneficiaries of the TSS worker’s efforts are different in some respects from those of the BB/BS. Whereas the typical BB/BS works almost exclusively with the child, the TSS worker works with the child and with the child’s family. Depending on the specific treatment plan, the TSS worker may help implement positive interactions between the child and the family, and may also support the caretakers’ positive parenting efforts. When implementing specific behavioral goals and objectives with the child, the TSS worker encourages parental participation, shares information, and seeks to transfer information and skills to the parents. These functions are unique to the TSS worker.

Most fundamentally, in interacting with the child, the TSS worker's goal is to support the child's *behavioral health functioning and emotional well-being*, not to enrich the child culturally, simply spend time with the child, or make the child a part of the worker’s extended family. The TSS worker’s specific, therapeutically sanctioned efforts are based on an ongoing feedback loop to and from the treatment team. The components of this feedback loop are: the child's identified needs, the treatment plan goals and objectives, the TSS worker's observation of the child's behavioral patterns, feedback from the TSS worker to the team, and feedback from the child and family back to the TSS worker.

## **Summary**

The culture of behavioral health services is different than the culture of volunteer organizations that provide Big Brothers and Big Sisters to children and adolescents. Both are valid endeavors, and each can be helpful. However, while empathy, respect, and other humanistic qualities are important in both situations, there are important differences. The Big Brother or Big Sister has a more personal relationship with the child, with less strict boundaries. In fact, a Big Brother who chooses not to share his or her personal life with the child might be seen as detached and disinterested. The TSS worker, on the other hand, shares personal life only when it is therapeutic to do so and when it has been approved by the TSS supervisor. Friends and family of the TSS worker are kept separate from the child. The TSS worker is providing a medically necessary behavioral health service and is part of a team whose mission is to address the child's serious emotional disturbance, in partnership with the family. In respecting role boundaries, the TSS worker does not preclude the possibility of a meaningful connection with the child. On the contrary, a committed TSS worker connects with the child and also contributes to the child's behavioral health and positive community adaptation.

## THERAPEUTIC STAFF SUPPORT IN THE SCHOOL: ADDRESSING SPECIAL CHALLENGES

### **Introduction:**

There are special challenges associated with the use of Therapeutic Staff Support (TSS) in the school setting, in large measure due to mental health services being provided within a separate, independent system—the school—that has its own structure, rules, methodologies, and culture. Teachers rightfully regard themselves as experts on their children, so the manner of the TSS worker’s approach to the teacher is as important as the specific information conveyed. It may be difficult for the TSS worker to know who to contact within the school, and when. The rapid pace of the school day may make it unclear when the TSS worker and classroom teacher can best debrief about the child. It may also be unclear just how much information the teacher possesses about the child and how much is appropriate, given possible confidentiality issues.

### **School Participation at the Interagency Team Meeting:**

It therefore follows that school representation at the interagency team meeting—typically a sound practice, even when in-school TSS services are not being given—becomes essential when TSS is being planned for, or provided within, the school. While participation of the child's primary classroom teacher is essential, the participation of more than a single school representative constitutes best practice. In addition to the primary classroom teacher, other school representatives may include the guidance counselor, principal, vo-tech instructor, coach, special education teacher, or other teachers who know the child well.

Since TSS is never intended to function as a stand-alone mental health service, it is expected that the initial school-based contact between the TSS worker and the school be mediated by a mental health professional (e.g., a Mobile Therapist, Behavior Specialist, or outpatient therapist, or the TSS supervisor), with the participation of the family. Such a meeting offers an opportunity for all parties to clarify many critical issues. These issues include the followings

1. The child's most immediate needs;
2. Efforts to date by the school;
3. The current school-related goals and objectives within the child's treatment plan;
4. The specific hours, school-related settings, and roles of the TSS worker;
5. The nature of TSS oversight by a designated mental health professional;
6. Mechanisms for informal exchange of information between the teacher and TSS worker;
7. Mechanisms to set up a treatment team meeting, as needed;
8. Specific data to be collected and reviewed;
9. Other mutual expectations of school, mental health staff, and family;

10. Confidentiality issues, when applicable; and
11. Criteria for service tapering and eventual discontinuation.

**Collaboration, Not Just Tending the Child, is the TSS Goal:**

As regards collaboration, the TSS role within the classroom involves not just supporting and redirecting the child, but also exchanging information and collaborating actively with the classroom teacher, in the manner identified within the treatment plan and as directed by the mental health professional. In this way, the TSS worker's efforts not only support the child's coping but also assist the teacher and school in making necessary individualized accommodations to benefit the child over time, so that TSS need not continue indefinitely. The effectiveness of such collaboration is subject to periodic internal and team review, including regular communication with the family.

## PROMOTING APPROPRIATE USE OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN AND ADOLESCENTS

Since all children's treatment and services should be guided by CASSP Principles, this should include the use of psychotropic medication for children and adolescents, when clinically indicated. Unfortunately, for a variety of reasons, this is not always the case. Not all children with serious emotional disturbance who could benefit from psychotropic medication are receiving it. Not all families are given sufficient information to make informed choices about psychotropic medication. Not all children receiving psychotropic medication are benefiting from the integrated efforts of therapist and treatment team with the prescribing physician. Not all parents of children on medication have sufficient access to the prescribing physician, so that questions and concerns can be addressed when they arise. Not all physicians have the opportunity to get to know the child and family in ways that would more fully support holistic treatment.

It is imperative that, collectively, we move the system of care forward so that psychotropic medication can more fully fall within the umbrella of CASSP. Achieving this goal requires discussion, changes in policy and funding, and support of best practices consistent with CASSP Principles. What follow are some clinical and ethical guidelines for the use of psychotropic medication for children and adolescents with behavioral health problems. It is hoped that these assumptions will support the efforts of both practitioners and families in promoting the partnership necessary for psychotropic medication to be agreed upon, when needed, and to be effective, when given.

### ***Fifteen Assumptions about Use of Psychotropic Medication for Children and Adolescents with Mental Health Problems***

1. Psychotropic medication can often make a contribution to the treatment of a child's social-emotional disturbances, and should be *considered*, as part of comprehensive, integrated treatment planning.
2. Social-emotional disorders known to be physiologically-based and responsive to psychotropic medication should *usually* be treated with such medication, carefully chosen and individualized for the child.
3. The use of medication, as with all mental health treatment, should be *collaborative* with families and guided by a team process and *CASSP Principles*. Medication decisions ultimately rest with parents and child.
4. Psychotropic medication should be used for therapeutic reasons, with the goal of addressing symptoms and promoting the functioning of the child, not as a form of punishment or social control.

5. A critical aspect of use of medication involves *education* of family/caregivers and child about the disorder being treated, the role of medication in mental health treatment, and the specific role of the recommended medication(s), including therapeutic effects and possible side effects.
6. Education should be ongoing, so that caregivers and child are informed and the physician becomes a *consultant* to the family.
7. Discussions and use of psychotropic medication should recognize and address an individual's and family's *cultural beliefs*.
8. Discussions and use of psychotropic medication should respect the *age-appropriate needs* of the child, including the need for confidentiality from peers, if desired, and concerns about specific side effects.
9. Medication is never the whole answer, and does not "fix" the child. *Mental health treatment* should address the needs and development of the whole child. *Accommodations* should be made to promote functioning and address the disorder, as needed.
10. It should be understood that *individuals* create desired change, not medication. Medication removes physiologically-based *obstacles* to change, enabling the individual's *own efforts* to be more effective. Even with medication, clinical disorders may remain difficult to treat.
11. A child's use of medication is under the *supervision* of the parents/caregivers. Specific arrangements need to be worked out for each child, among caregivers, physician, and child, based on the child's age and level of responsibility.
12. Use of medication should be responsive to the child's *changing needs* and improvements over time. Medication use should also be guided by current information about the disorder being treated and most effective prescribing practices.
13. Effects of psychotropic medication should be *documented* in progress notes, as well as in psychiatric/psychological evaluations and treatment plans. Medication and dosages should be clearly identified, with changes noted.
14. When medication is refused by child (or by natural family), specific efforts should be made to offer education and to address the concerns. These efforts should be documented in evaluations, progress notes, and the treatment plan.
15. For medication to be effective, the child needs to *work with it*, not merely swallow the pill, and the parents need to actively support the medication plan. Therefore, professionals should welcome questions from child and family, and provide additional material as available, upon request.

## References

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*NAMIfacts*, dealing with various psychiatric disorders (telephone (703)-524-7600).

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Yudofsky, S., Hales, R., & Ferguson, T. *What you need to know about psychiatric drugs: A consumer's guide to the full range of psychiatric medications*. Washington, DC: APA Press, 1991.

## COMMON MYTHS AND MISCONCEPTIONS ABOUT PSYCHOTROPIC MEDICATION FOR CHILDREN AND ADOLESCENTS

*“Medications are drugs, and drugs are bad for children.”*

*“Only ‘weird’ and ‘crazy’ children need medication.”*

*“Medication turns children into ‘zombies.’”*

*“Medication is used to control the child, not to help the child.”*

*“Medication makes children ‘high.’”*

*“Medication, especially stimulants for ADHD, lead to drug addiction.”*

*“If the child really wants to change, he can do it without medicine.”*

*“If a child needs medication, it's because she is ‘weak.’”*

*“Even if the child improves on medication, the improvement will be due to the medication, not the child.”*

*“Medication will make my child someone different from whom he really is.”*

*“Taking medication will just make my child feel self-conscious and ashamed.”*

*“By telling me that my child needs medication, you're saying that I'm a failure as a parent.”*

*“You're using my child for an experiment.”*

*“The child won't take the medicine anyway, so why bother with the hassle?”*

*“The other kids will tease my child and make her feel awful.”*

*“If my child agrees to the medication, then fine. But that's between you and him.”*

*“Even though I don't agree, I'll give the child the medicine. Kids can't tell the difference anyway.”*

## POSSIBLE CLINICAL INDICATIONS FOR PSYCHOTROPIC MEDICATION FOR CHILDREN AND ADOLESCENTS

1. The child or adolescent with a psychiatric disorder that is *known to be responsive* to psychotropic medication (Schizophrenia, Bipolar Disorder, OCD, ADHD, some Depression).
2. The child or adolescent with a psychiatric disorder that is *often responsive* to psychotropic medication, especially if no improvement occurs through other approaches (Depression, Panic or other Anxiety Disorders).
3. The child or adolescent for whom a *co-occurring or secondary condition* requires treatment (child with PDD with signs of severe ADHD or severe aggression, the child with a substance abuse and a psychiatric disorder).
4. The child or adolescent with symptoms suggestive of a disorder, with a *strong family history* of that disorder and positive family response to use of medication (Depression, Bipolar Disorder), especially when other interventions are insufficient.
5. The child with an *adjustment disorder or acute response to stress*, with symptoms typically responsive to psychotropic medication (anxiety following death of parent, or following natural disaster).
6. *Crisis*: An acutely agitated or dangerous child, in need of emergency assessment and possible psychiatric hospitalization.

## INITIAL PSYCHOTROPIC MEDICATION DISCUSSION WITH THE CHILD AND FAMILY, FOLLOWING THE PSYCHIATRIC EVALUATION

1. Connect with the child and family.
2. Ask the child/family to review their concerns first.
3. Obtain medication history, including past outcomes.
4. Ask about medical conditions or problems. Obtain name of primary care physician.
5. Summarize clinical findings, in plain language. Reference child/family concerns, as applicable.
6. Identify applicable diagnoses. Allow time for response and questions.
7. Describe overall treatment approach to the disorder.
8. Ask about particular concerns/beliefs regarding psychotropic medication.
9. Describe the role of psychotropic medication in general, and the potential role of specific psychotropic medication for the child.
10. Review Medication Information Sheets and other applicable materials, to include: name of medication, indications, expected outcomes, possible side effects.
11. Allow time for questions and further discussion.
12. If agreement is made to pursue medication:
  - a. Obtain signatures on Consent to Medication Form and on Confidentiality waiver, for permission to confer with the primary care physician or nurse practitioner.
  - b. Give prescription for appropriate medical screening.
  - c. Give prescription for medication, if appropriate, with clear instructions.
  - d. Formalize follow-up plan and next appointment.
13. If additional time is needed by the child and family to consider medication recommendation:
  - a. Determine if other family members need to be included.
  - b. Set up follow-up plans, including next appointment.

## PSYCHOTROPIC MEDICATION: ADDRESSING CHILD AND ADOLESCENT CONCERNS (With the Child Alone, or the Child with the Family)

1. Connect.
2. Return to earlier discussion with the child and family.
3. Clarify the nature of the child's concerns/possible preconceptions about psychotropic medications.
4. Pursue these themes:
  - a. Physiologically-based conditions require medical treatment (e.g., use of medication)
  - b. The locus of control remains with the child.
  - c. Medication overcomes a physiological *barrier* or *obstacle*. The *child* produces the change.
  - d. Side effects, especially sedation where applicable, will be managed carefully.
  - e. Medication is to be continued only if effective. Will monitor target symptoms closely.
  - f. Confidentiality concerns, when present, will be respected.
5. Use metaphors and analogies:
  - a. Common medical disorders—diabetes or asthma.
  - b. Use of Tylenol, to eliminate headache: the individual is then better able to “be real self” and “do own thing.”
  - c. Sports metaphor involving basketball: medication gets “an assist,” but the individual actually scores “the basket.”
6. Selective use self-disclosure: own children or relatives on medication.

## BIOPSYCHOSOCIAL TREATMENT: SELF-ASSESSMENT

- Do I have a partnership with the family?
- Do I have adequate information?
- Is my treatment strengths-based?
- Are all relevant child-serving systems participating?
- Are natural resources identified and being used?
- Is my treatment culturally competent?
- Do I understand the child, as a unique person, in relevant life domains?
- Is there a shared hypothesis regarding the nature of the problem?
- Is the treatment plan meaningful and practical?
- Is the child in need of psychotropic medication?
- Are there medical concerns in need of assessment, treatment, and/or monitoring?
- Are written reports and documents clear, comprehensive, and respectful?

# BEHAVIORAL HEALTH SUBMISSIONS

## KEY AREAS TO ADDRESS IN EPSDT MENTAL HEALTH SUBMISSIONS

*The following checklist has been developed to help providers and practitioners know what they should include in service plans for children and adolescents with severe emotional disorders who are eligible for EPSDT services. Addressing each of the ten areas listed below will help to ensure that services are following CASSP principles and that they will be approved and funded by EPSDT.*

1. Identification/discussion of the child's family, community, education, and human service/mental health contexts.
2. Identification of the child's specific needs and problems.
3. Identification of the family's needs, as applicable.
4. Identification of the child and family strengths.
5. Discussion of the specific services provided to date for the child and family, and responses by the child and family, including:
  - a. All mental health services, including prior EPSDT services;
  - b. Educational and placement services;
  - c. Services from other child-serving systems;
  - d. Human services received by parents, when applicable.
6. Discussion of the nature of family participation in treatment.
7. Discussion of how planned and requested services will address current needs, as defined. Cultural competence.
8. Description of the child as a real person, in Psychiatric/Psychological Evaluation Report.
9. Development of a strengths-based treatment plan, including:
  - a. Positive, observable objectives for the child;
  - b. Goals and objectives for the family, when applicable;
  - c. Definition of staff responsibilities;

- d. For resubmissions: discussion of the degree of attainment of previous goals/objectives and overall progress.
10. Inclusion of a comprehensive plan of care summary, listing:
- a. all services from child-serving systems (list requested EPSDT services first and identify);
  - b. the child's education setting;
  - c. Community services.

## OBTAINING SERVICE APPROVALS

### Suggested Approaches with Managed Care

*Note: No protocol can guarantee approval of all service requests. The following represents an integrated approach involving the prescriber, interagency team and clinical documents to assist in assessment, service selection and documentation of medical necessity for requested services.*

#### **A. Administrative:**

1. Learn the terminology and procedures of the managed care organization.
2. Be sure that all necessary documents are timely, and are submitted together.
3. Be sure that all service requests are clearly identified, with requested start of continuation dates, requested frequency and intensity of the service, and requested length of service period.

#### **B. Suggestions for Psychological Evaluations:**

1. Adequate data base
  - a. The child in context
  - b. Specific symptoms, problems, needs
  - c. Strengths and goals to support and build on
  - d. Functioning of the child in multiple life domains
  - e. Documentation of active treatment, including interventions to date (planned interventions, for new requests), their effectiveness, and specific interventions by mental health staff
  - f. Indications for and use of psychotropic medication
  - g. Other relevant information, at the discretion of the prescriber
2. Active description of the child during a face-to-face interview
  - a. Routine mental status functions
  - b. Manner of relating to psychologist or other participating adults
  - c. Strengths, ideas, goals, concerns of the child; e.g., child's own voice emerges.
3. Case formulation/hypothesis
4. Clear rationale for proposed service package and for each specific service

5. Evidence of coordination with interagency team and with treatment plan
  - a. Congruence of identified needs, problems, concerns
  - b. Summary of operant service period and course of treatment
  - c. Consistency of diagnosis
  - d. Consistency of recommendations and identified services

**C. Treatment Plan as Work Plan**

1. *Updated:* Detailed update provided on degree of attainment of previous treatment plan
2. *Comprehensive:* Multiple life domains incorporated in treatment plan, including any domain in which services are recommended
3. *Strengths-based:* Strengths of the child, family and community are identified and built on
4. *Observable:* Objectives observable (and measurable), involving the child or family as the agent of change, and consistent with identified goals
5. *Methods/Interventions:* Actions by key persons delineated, not just listing of specific service or service provider. Includes actions/tasks of service providers in accordance with stated goals and objectives, and actions/tasks of family and non-professional resource persons
6. *Clear:* Tasks clarified for therapeutic staff support worker, when involved
7. *Services and Settings Scheduled:* Weekly schedule identified for services and settings for each service

**D. Community-based Service Selection**

1. Use and completion of the “Twelve Treatment Issues” document prior to determining service needs
2. Service selection based on eligibility of the child for specific mental health services, in accordance with established admission and continued care guidelines for services
3. For Home/Community Services, determination of appropriate level of care (I-IV) of the child or adolescent, based on clinical presentation and severity
4. Service requests individualized, not cookie-cutter
5. Service request reflects the child’s actual needs.
6. Service request reflects clinical progress and provides rationale for requested amount
  - a. Reduction in response to improvement, unless needed to sustain progress

- b. Explanation for requested increase
  - c. Treatment reassessment and modification, in response to stalemate
7. Service request based on careful analysis of specific settings, areas of functioning within, and time of need
  8. Service use incorporates professional services, natural supports, and need for independent problem solving and practice time
  9. Service plan addresses criteria for service tapering

**E. Special Considerations for Extension of Residential Treatment**

1. Nature of active treatment. Approaches to symptoms and core issues and responses
2. Summary of treatment goal attainment
3. Continuing needs and rationale for continued stay
4. Family and community participation
5. Discharge plan and specific steps in support of community-based or alternative aftercare

# ADDITIONAL DOCUMENT

## CORE PRINCIPLES

### Child and Adolescent Service System Program (CASSP)

Pennsylvania's Child and Adolescent Service System Program (CASSP) is based on a well-defined set of principles for mental health services for children and adolescents with or at risk of developing severe emotional disorders and their families. These principles, variously expressed since the beginning of CASSP, can be summarized in six core statements. When services are developed and delivered according to the following principles, it is expected that they will operate simultaneously and not in isolation from each other.

**1. Child-centered**

Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

**2. Family-focused**

Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.

**3. Community-based**

Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

**4. Multi-system**

Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

**5. Culturally competent**

Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

Note: Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

**6. Least restrictive/least intrusive**

Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

**Adopted May 15, 1995**

**PA Department of Public Welfare, Office of Mental Health and Substance Abuse Services**