DOCUMENT RESUME

ED 360 791 EC 302 363

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TITLE	Case Management for Families and Children.
INSTITUTION	Portland State Univ., Oreg. Regional Research Inst. for Human Services.
SPONS AGENCY	National Inst. of Mental Health (DHHS), Rockville, MD.; National Inst. on Disability and Rehabilitation Research (ED/OSERS), Washington, DC.
PUB DATE	93
NOTE	21p.; "Focal Point" is "The Bulletin of the Research and Training Center on Family Support and Children's Mental Health."
PUB TYPE	Collected Works - Serials (022)
JOURNAL CIT	Focal Point; v7 n1 Win-Spr 1993
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	*Caseworker Approach; *Emotional Disturbances; Family Involvement; Government Role; *Mental Health Programs; Parent Attitudes; *Parent Participation; *Professional Education; Program Evaluation; Program Implementation; *Public Policy; Research Needs; State Agencies; State Government
IDENTIFIERS	*Case Management

ABSTRACT

This theme issue of "Focal Point" offers an overview of a range of children's mental health case management issues. Articles include: "Case Management for Families and Children" (Theresa J. Early); "Expectations of Case Management for Children with Emotional Problems: Parent Perspectives" (Richard Donner and others); "Principles of Training for Child Mental Health Case Management" (Marie Weil and others); "Case Management Research Issues and Directions" (Barbara J. Burns and others); and "Implementing and Monitoring Case Management: A State Agency Perspective" (Lenore B. Behar). The articles discuss functions of case management; principles of development of case management programs; the relationship between case managers and families; the core areas of child mental health case management training, which consists of values, knowledge, and skills; and the role of the states in promulgating philosophy and attitude changes, setting program policies and standards, providing training, ensuring funding, and monitoring and evaluating services. The bulletin concludes with profiles of staff of the Child, Adolescent and Family Branch of the Center for Mental Health Services of the U.S. Substance Abuse and Mental Health Services Administration, and with notes concerning research projects, programs, and conferences. (JDD)

WINTER/SPRING 1993

FOCAL POINT®

CASE MANAGEMENT FOR FAMILIES AND CHILDREN

Case management for children and adolescents with emotional and behavioral disorders and their families is a developing and rapidly expanding service. Roots of children's mental health case management lie in mental health services to adults with severe and persistent mental illness, particularly the Community Support Program, dating to the late 1970s, and its emphasis on case management. The development of case management for various populations is driven by several common concerns: a need for integrated services to overcome the fragmentation of service delivery systems and to ensure care for the whole person, a need for continuity of care as needs change, and a need for individualized treatment to meet individuals' different constellations of need.

What is "case management"? Other terms used to denote the "case management" service or activity include service coordination and therapeutic case advocacy (1). The functions of case management are:

1. Assessment—*the process of determining needs or problems;*
2. Planning—*the identification of specific goals and the selection of activities and services needed to achieve them;*
3. Linking—*the referral, transfer or other connection of clients to appropriate services;*
4. Monitoring—*ongoing assurance that services are being delivered and remain appropriate, and the evaluation of client progress;* and
5. Advocacy—*intervention on behalf of the client to secure services and entitlements.*

In a survey of parents who attended a national case management conference or were state leaders of parent organizations, participants were asked to select, from a list of seventeen, the six principles most important to them and were invited, as well, to add principles. The five principles generated follow and are useful in the development and evaluation of case management programs:

1. Parents should have a major role in determining the extent and degree of their participation as case manager. Much of what a case manager does is what parents usually do for their children. A case management service that operates according to this principle openly engages the parent in determining their level of involvement. A program that mutually identifies what tasks are required to obtain needed resources for a child and mutually identifies who has the time and energy to work on the task is one that operates according to this ideal. In this era of wrap-around funds, this principle suggests that those parents who desire should have the "checkbook" for the purchase of needed services. It further suggests that some parents should receive a salary for being the case manager for their child.

2. Case managers should have frequent contact with child, family and other key actors. Agencies in which case management is office-based and the case manager is heavily scheduled present barriers to parental contact. A case manager with a large caseload is less available to parents

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on Family Support and Children's Mental Health

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and children. Programs should enable case managers to spend time with youth in the community. Case managers need to work during hours in which both parents and children are available—after school and work.

3. A single case manager should be responsible for helping families gain access to needed resources. This principle addresses a structural element. One of the complexities of case management with families of children with emotional disorders is the number of community "systems" (e.g., education, child welfare, mental health, juvenile justice) with which the child is involved. Each system may provide a case manager. Moreover, one family may have several case managers from the same system. To avoid an endless parade of case managers, the community needs to coordinate efforts and allow the family to work with a single case manager.

4. Parents and child should be involved in decision-making. Case managers who conduct assessments *with* rather than on parents and children are involving parents and children. Case managers who ask caregivers what they need to care for the child and ask children about what they need to live in the community are involving families in planning. Case managers who identify tasks with parents and children and jointly determine who will be responsible for which task are operating according to the involvement principle.

5. Case manager roles and functions should support

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The Research and Training Center was established in 1984 with funding from the National Institute on Disability and Rehabilitation Research (NIDRR) in collaboration with the National Institute of Mental Health (NIMH). The content of this publication does not necessarily reflect the views or policies of the funding agencies.

We invite our audience to submit letters and comments.

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and strengthen family functioning. Case managers should work with caregivers to assist them to acquire what they need to care for their child and maintain a safe, healthy family. Case managers are working with children to help them live successfully in a family environment and become functioning adult members of the community.

These principles provide an overlay for analysis of the four identified dominant approaches to case management:

Outpatient therapy approach. Assessment in this approach is first driven by the need to obtain a DSM-III(R) diagnosis for both reimbursement and clinical purposes. The assessment process then blends into planning with the therapist working with the child and various family members in a mutual process of problem definition. The history of the family and the situation are seen as important elements in understanding the problem. The case plan follows the format indicated by the mental health center and its funding agencies. Linkages to other services and agencies takes place as the case manager and the child or parent see the need for additional services. Monitoring and evaluation in this approach focuses on the work done by the child and parent between sessions.

Brokerage approach. The main responsibility of a case manager employing the brokerage approach is to make arrangements for clients to receive services. Those who subscribe to this approach believe that the service delivery system is neither well-coordinated nor flexible. In order for children with emotional disorders to receive the full range of services they need, someone must be available who knows what services there are, knows how to access them, and plays the role of broker on behalf of clients. Assessment is based upon the child's functioning (behaviorally) in the community or current placement. Case planning consists of the case manager identifying services to meet the needs of the child and those of the family, if the family is involved. Linking, or establishing the means by which the child or family acquires the services, is an element of this approach that varies widely and is influenced greatly by how the broker views their advocacy function. Monitoring or evaluation is the process of determining if the current mix of services is meeting the needs defined in the case plan and if different or additional services are required. As with linking and advocacy, this function varies widely.

Interdisciplinary or interagency team approach. The team approach is really two similar yet distinct approaches. The *interdisciplinary* team is often used when the child is seen as having multiple medical needs, such as children with a variety of developmental delays, medical problems and emotional disorders. In this case the team consists of a group of specialists. Often this model is used as an early intervention service. The *interagency* team, on the other hand, is designed as a coordinating mechanism used when the child is currently involved in several service systems such as the court, special education, child welfare and mental health. The team is composed of a group of service providers from different agencies. Assessment is conducted by the various members of the team. The plan is developed through the combination of team perspectives and is normally a group of specialized services reflecting the agencies or specialties represented by the team members. Linking is performed in a variety of ways. In this approach, advocacy is often seen as less important because the gatekeepers to the services are represented on the team, take part in the decision-making, and can assist the "client" to obtain the indicated services. Monitoring or evaluation is often seen as the responsibility of the individual service providers.

Strengths approach. The strengths approach to case management with children and families is more than the philosophy of identifying child and family strengths, it is a particular way to carry out the functions of case management. Assessment in this approach involves the identification of personal abilities and family resources. Those things that the child or family caregiver does well are strengths upon which case plans can be built. These strengths are the foundation for the case plan. Case planning in the strengths approach is child and caregiver directed and consists not of problem-solving but of prospective goal-setting. Linking the child and family to resources is dictated by the mutually defined case plan. Once the steps to acquiring a resource are clear, responsibilities are shared with the child and family performing specified tasks and the case manager handling other tasks. Monitoring and evaluation are ongoing processes dictated by the case plan. Advocacy takes several forms from assisting the child and caregiver to learn the steps necessary for acquiring a resource, to going with the child or family to negotiate with a service provider, to educating agencies, professionals, and individuals about making reasonable accommodations for families and children with emotional disorders. The focus is not upon the case manager advocating for the youth or family caregiver but upon advocacy being integrated into the goal-setting process through mutually determining the tasks required and who will participate in a particular task and who will take responsibility for task accomplishment.

Hopes for case management are high, yet our knowledge is just developing. This challenges us—parents, researchers, practitioners, and policy-makers—to work together to identify the tasks, structures, and methods that produce desired results, including normalization of chil-

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dren with serious emotional disorders, satisfy the norms established by parents, and assure the safety of both children and family caregivers. From this point of view it is less important who performs case management or what it is called; it is more important to focus on approaches that produce the desired results.

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EDITOR'S NOTE

Case management services were identified early in the children's mental health movement as a key component of a comprehensive system of care for children with serious mental, emotional or behavioral disorders. In the 1986 *A System of Care for Severely Emotionally Disturbed Children and Youth,* Stroul and Friedman observed that case managers are the glue who hold the system together. They noted that a case manager's functions—including coordinating the comprehensive interagency assessment of the child and family's needs, arranging for necessary services, and developing linkages among the various services and agencies—are the very activities that "'systematize' the system of care."

The critical role case management services play in the provision of care to children with emotional, behavioral or mental disabilities and their families has been recognized in three recent federal laws. **Public Law 99-660** requires states to develop a mental health plan to deliver community-based services to individuals with severe mental illnesses and further mandates the provision of case management services to those individuals who receive substantial amounts of public funds or services.

Further, **Public Law 99-457 (Part H)** launched an effort to improve services for infants and toddlers with special needs and their families. States choosing to participate in the federal infants and toddlers program provide each child and family with a written individualized family service plan (IFSP) developed by a multidisciplinary team that includes the child's parent or guardian. The Congressional Record (1986) provides that the IFSP must provide the "name of the case manager...who will be responsible for implementation of the plan and coordination with other agencies and persons." (p. H7895).

The new Child Mental Health Services Program, authorized by **Public Law 102-321** and implemented by the Center for Mental Health Services, will provide grants to states, political subdivisions of states, and Indian tribes to provide a broad array of community-based and family-focused services for children with serious mental, emotional, and behavioral disorders and to enable communities to develop coordinated local systems of care that involve mental health, child welfare, education, juvenile justice, and other appropriate agencies. Under this program, case management is identified as a critical function and is required for all youngsters offered access to the system of care though the specific approach and intensity of services may vary.

In recognition of the absence of literature on case management in children's mental health, Portland Research and Training Center staff hosted a conference with the purpose of assembling papers for a book on the subject. The Research and Training Center' s conference, entitled *Building on Family Strengths: A National Conference on Case Management for Children with Emotional, Behavioral or Mental Disorders* was held March 28-30, 1992 in Portland, Oregon. Approximately 350 parents and professionals from 39 different states, the District of Columbia and Guam were in attendance. The conference provided state-of-the-art information about case management for children with emotional, behavioral and mental disorders and their families; created a forum for participants to interact and exchange information about a wide range of case management issues; and, further, provided an opportunity for authors to present their work and gather feedback useful in the preparation of the book.

Nearly one-third of the 350 participants were family members. Many family members who attended were sponsored with Research and Training Center funds, by state or local parent organizations, or by state mental health agencies. The extent of cooperation and support provided for family members by state mental health agencies suggests that state support for family participation has increased substantially during the last few years.

This issue of *Focal Point* offers a brief overview of a range of children's mental health case management issues and—in the five leading articles excerpted from the upcoming book with the working title *Building on Family Strengths: Case Management for Children with Emotional, Behavioral or Mental Disorders*—provides a snapshot of the forthcoming book. Publication is tentatively scheduled for Fall 1994. Ordering information may be obtained by contacting: Paul H. Brookes Publishing Company, P.O. Box 10624, Baltimore, Maryland 21285-0624; (800) 638-3775.

EXPECTATIONS OF CASE MANAGEMENT FOR CHILDREN WITH EMOTIONAL PROBLEMS: PARENT PERSPECTIVES

Six parents involved in Keys for Networking, a statewide Kansas parent organization, met and shared their expectations of case management and case managers in five areas: (1) the relationship between case managers and families; (2) case managers' attitudes and beliefs; (3) the role of the case manager with formal services; (4) informal resources; and (5) organizational issues that effect the implementation of the case management service.

The Case Management Relationship

In order to accomplish the tasks of case management, parents believe case managers need the skills to establish positive, ongoing, trusting relationships with parents, their children and agencies. "The ultimate success of case management depends on the relationship between the case manager and their ability to work with the parent and the child."

Parents want case managers to ask them what they need and to have skills in helping locate the resources and supports that will help parents meet those needs. This includes the ability to translate family concerns into resources and services. For example, if parents say they need a break from being with their child, the case manager translates that into a service such as respite care.

Parents expect the case manager to have the competence to highlight family strengths, to see the value of each member of the family and to build on these strengths. Case managers should exhibit flexibility, ease and a personal touch. Parents want case managers to reach out to them and not always expect families to contact the case manager.

In effect, parents want case managers to be like extended family members who get paid. Case managers should be interested, involved, available, supportive, and know when it is time to leave. At the same time case managers need to know their own limits and how to take care of themselves.

Case Managers' Attitudes and Beliefs

It is not enough for parents that case managers have the skills to do the tasks of their job, they also need attitudes that support families. They need to see families in a positive, non-blaming way and know that, no matter what, parents are invested in their children. Parents also want case managers to be invested and committed to them and their children. Most importantly parents expect case managers to have the attitude that children and youth should be with families and that families are the experts on their needs. Parents want case managers to be able to look at the world from the family's perspective and set priorities based on what the family wants. Case managers must be sensitive to cultural, environmental, racial, religious and sexual orientation differences.

Working with Formal Service Systems

The formal service systems (e.g., education, mental health, child welfare) available to children are often fragmented and function with little or no interaction. Parents expect case managers to be in touch with all of the other persons involved in working with them and their child. This requires case managers to be familiar with community resources and how to access them. Parents expect case managers to develop relationships with other providers so that they have the "pull" to get things done and the skill to know whom to contact and when. Parents want the case manager to have the capacity and the authority to make decisions with them regarding their child. This is especially critical in a crisis when families need to have assistance in getting emergency services.

The case manager needs to be aware of the regulations and eligibility criteria for other formalized services. For example, if a child is eligible for Medicaid services, the child's case manager should know what Medicaid will fund and should assist families in securing those services.

Working with Informal Resources and Supports

Parents want their children to be involved in routine age appropriate activities such as swimming, skating, Little League, school dances and summer camps. Accordingly, parents expect the case manager to be able to assist them in accessing non-traditional supports for their child. These supports may include recruiting volunteers to work with the child. For example, if a child is interested in scouting, the case manager might identify an individual who could attend scouting events with the child. The case manager should be available to the volunteer to help that individual understand the child so that both the child and volunteer gain from the experience.

Case managers should serve as a bridge to link families experiencing similar stress and should help create resources where they do not exist. For example, parents appreciate the support provided by case managers when they arrange for transportation for the child or family to appointments and activities.

Organizational Considerations

Case management services that are responsive to families must be flexible in all aspects. Caseloads need to be small enough for case managers to be involved with families. The service must be focused on the family and not just the child. The case manager's hours need to be flexible so that they can meet families at times when it is convenient for the family. They must be allowed to come to the family and provide transportation when needed. Case management services must be available to families at all hours. Someone needs to be available to respond to a parent's needs when a case manager is not available.

When case management is family sensitive and implemented in a comprehensive and integrative way it can be the backbone of a system of care for children with emotional disorders. When successful, case management can ensure that children and families receive the services and supports they need to keep their children at home.

Richard Donner, M.S.W.; Barbara Huff, *Executive Administrator, Federation of Families for Children's Mental Health, Alexandria, Virginia;* **Mary Gentry; Deborah McKinney; Jana Duncan; Sharon Thompson;** *and* **Patty Silver.** *The six women authors are each the parent of a child with a mental, emotional, or behavioral disability and have substantial experience seeking appropriate services for their child. With the exception of Barbara Huff, all of the authors live in the Topeka, Kansas area.*

PRINCIPLES OF TRAINING FOR CHILD MENTAL HEALTH CASE MANAGEMENT

In North Carolina a model for child mental health case management training is being implemented through a contract between the State's Department of Human Resources Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and the School of Social Work at the University of North Carolina at Chapel Hill. The model establishes a collaborative process for content development involving the State Division of Mental Health Children and Youth Program, three demonstration child mental health programs, a child mental health advocacy organization, and the School of Social Work.

Case managers in child mental health have a tripartite focus: on the child, on the family, and on the service system. Eligibility is determined by the child's need for service, but the case manager must focus equally on the partnership with the parent or responsible adult, and on service coordination and collaboration among service providers, as well as on the child. The interactions between the case manager and each focal point affect the interactions among all the parts. Effective case management requires a specific *value base*, *knowledge* relevant to the population to be served and the service system, and *skills* needed to provide the service, including relating to children in the mental health system, engaging in partnerships with their parent or responsible adult, and facilitating interprofessional collaboration. These three core areas form the foundation for child mental health case management training.

VALUES

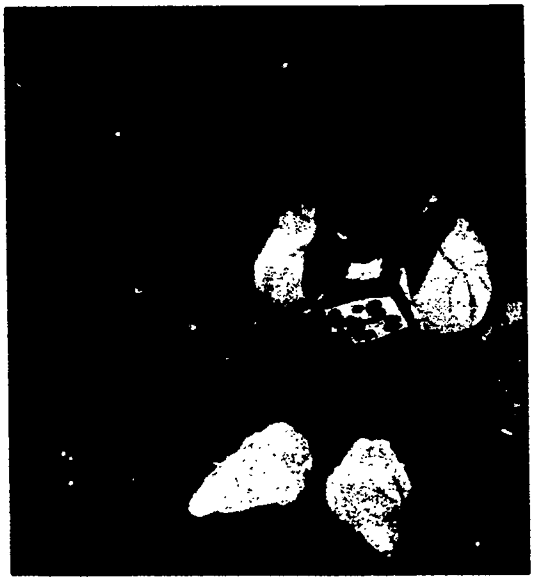
Case managers who believe that community-based services are the most relevant and appropriate for the child and the family will provide the intense involvement needed to assure that agencies, organizations, and individuals collaborate to support and preserve families. Case managers need to believe that families want what is best for their child. Indeed, families should be valued for knowing the child better than anyone else, although they may not fully understand the child's behavior. Case managers need to value family preservation to the point of leaving the family intact in times of crisis. When this is not possible the case manager will work toward family reunification. This may entail advocating on behalf of the child and the family for unavailable or inaccessible services.

Case managers must value the basic integrity of children and adults and respect the cultural, racial, ethnic and sexual orientation differences among individuals. They also need to appreciate families' varied coping styles, recognize that all families sometimes have difficulty coping effectively under stress, and believe that families generally have the capacity for positive change.

Case managers, frequently privy to strictly confidential information, must be keenly sensitive to client confidentiality, while recognizing the tensions inherent in working with multiple members of a family and with multiple agencies.

Working with families from an empowerment perspective involves promoting their ability to utilize their existing strengths to meet their needs (1). Case managers working from this perspective believe that community-based and family-centered services are the most relevant and appropriate for the child and the family.

Case managers need to value interprofessional collaboration as a means to problem-solving. They should respect the expertise brought by professionals from various disciplines within the mental health system and elsewhere in the service network.



KNOWLEDGE

Case managers need to understand the process and functions of case management and their role *vis a vis* the family and service providers, as conceptualized in the particular case management model used by their agency. They need specific information about relevant legislation and about state, local, and organizational policies affecting children and families. Case managers need information about agency policies relative to confidentiality to guide their actions as they encounter the ethical dilemmas that can be expected. They need to know how to access the local network of services for children ages birth to 18, such as those provided by day care and preschool settings, the school system, social service agencies, medical and health services, substance abuse programs, religious groups, and community organizations.

Case managers need information about the functioning of families, including how stress can affect the family system and how the family system affects its members. Case managers need an understanding of the total treatment process from assessment to termination.

Moreover, case managers need information on assessment strategies; they need to know what information they are expected to gather as part of an assessment and when changes in behavior or circumstances warrant reassessment. They need to know enough about child psychopathology to understand the common manifestations of those disorders frequently seen in children served by the mental health system. The case manager needs to be familiar enough with therapy models to help interpret the therapy process to the family and to evaluate therapy process. The case manager needs to know about all levels of service, including day treatment and hospitalization, how to determine when a transition is appropriate, and how to access the new level of service. The case manager needs to be familiar with primary medications used, frequent side effects, and reactions needing medical evaluation.

There will be times when keeping the family intact, even though valued, is neither safe nor wise for the child or another family member. Thus, the case manager needs to know how to assess the nature of a crisis and how to determine when a person needs to be moved to a safer place or a different level of service. In addition, this involves knowing when and whom to call for assistance.

SKILLS

Case managers' skills must be based on values consistent with effective practice and grounded in the case management model specified in their agency. The particular model obviously will shape training priorities for skill development, although some skills are basic to all models. For instance, broad skills in communicating with others are essential.

Child mental health case managers should function from a family empowerment perspective to enable parents to support their child's development and to represent family interests to other service providers. Case managers need specific skills in working with families in preparation for assessment, in involving them in the development of the treatment plan, in reframing issues, in working through crises, and in helping families to maintain motivation at predictably difficult points in therapy. Case managers will also be engaged in capacity building and in decision-making with the family.

Case managers, from their vantage point as service coordinators, are in a unique position to identify service gaps. In order to address these gaps, they will need skills in advocating for particular children and families. They will also need skills in advocating for services, which may involve facilitating advocacy groups.

Case management programs rely on different models for service planning. Frequently, the case manager is responsible for assembling relevant professionals to work with a particular family or for collaborating with an existing team. Where decisions are made in a group context, the case manager needs specific skills in group facilitation (2, 3).

Regardless of case management model, all case managers need skills in assessment, information gathering, problem analysis, planning, negotiation, collaboration, problem-solving, decision-making, and advocacy (4). All case managers will need skills in documentation and record-keeping. All will be involved in transitions to different levels of service, in termination, and in evaluation of client outcomes, as well as the case management process and the service system and need skills for these complex functions.

Because of the stigma attached to mental health services, it is important that case managers be able to interpret those services to others. In this way, case managers can provide an important bridge between the family and the mental health system, and between mental health and other services within the service network.

Looking to the Future

Training in case management in child mental health will need to take into account the trend in service delivery systems toward thinking in terms of wrap-around services geared to the particular needs of the child and family, rather than in terms of categorical services delineated by agency function. This increased emphasis on tailoring services to meet the needs of the child and family will increase the importance of case management in creating, arranging for, and coordinating services. Collaboration among service providers is critical to the success of such family-centered services. The case manager plays a key role in ensuring that the collaboration essential to such service provision takes place. Carefully designed training programs can help to assure that case managers in child mental health are prepared to assume leadership in the provision of community-based and family-centered services that meet the needs of children and families.

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Parents' Perspective: Were There Good Times?

Three weeks to graduation day. Yes, it's hard to believe. How did we make it through K-12 — constantly at odds with the school system? All the pain, embarrassment, guilt, and the sense of hopelessness and uselessness.

Our son is emotionally impaired along with some mild neurological problems. He is our first born and oh, we love him so. For thirteen years we've struggled to seek the professional help that would make it better. We grasped at each new theory, new diagnosis—hoping that we would be a "normal happy family" at last.

We lived through the tears when Cub Scouts failed, no one wanted him on their sports teams, and the absence of party invitations—the shunning of a little boy because "he's different" or "he misbehaves." The years went by and the anger and frustration grew. The tears still came, but only after the violent verbal abuse. Our younger son shed his own tears because his life, too, depended on his brother's mood swings and behavior. "Why does my brother do these awful things?"

The high school years brought all of the stages of independence—only for us more failure. Friends passed drivers' education and got their licenses. Our son failed the course and was made the spectacle of the class. He faced the stigma and isolation of being "special ed." There were no after-school jobs. "Good students are so plentiful, who wants to bother with one who needs a little extra?"

We faced the milestones along with the rest. We did it alone with many a family secret kept as best we could. There must have been some bright spots along the way, but day to day there was always tension and many problems to face.

As we reach this graduation day of melancholy, we know it means a rocky future, which we will face alone, but we do so with a sigh of relief. No more school staff to convince—WE KNOW OUR SON AND HE IS NOT BAD!!!

I write this to remind parents to savour the good moments. It is sad when the good moments are lost in our memories.

Cindy Fales. *Cadillac, Michigan. Ms. Fales is a mother, advocate and Community Mental Health Board member.*

Editor's Note: Parents are invited to submit contributions, not to exceed 250 words, for the *Parents' Perspective* column.

CASE MANAGEMENT RESEARCH ISSUES AND DIRECTIONS

There is a virtual absence of well-controlled studies of case management in the children's mental health field. In the absence of research on case management for children and youth an extension of studies on adult populations may prove helpful. Such comparisons should be made with caution, however, as children and adolescents may differ significantly from the adult population in regard to their developmental needs, services required and legal status. The needs of the infant may differ from those of the troubled teenager; similarly the needs of a young adult in transition differ from those of the adult or elderly person with chronic mental illness. Different agencies may be involved with adults and children. While adults may require multiple services from many agencies, children are always subject to multiple agencies and legislative mandates and have only the legal status of a dependent. They may be wards of the court, foster children, or subject to parental control. Key research questions include the following:

Models. Can adult models of case management be adapted for children and youth or are there well-delineated child models? How do case management models vary for different developmental stages or diagnoses? To what extent does the choice of model adopted depend on the context of the service system or systems in which it is embedded?

Organization and service system context. Which agency should be responsible for the provision of case management? What federal, state or local agencies or mandates are involved? Does the case management function belong within the service organization or outside of it? If placed within the organization there is the risk that advocacy needs will go unmet because of the potential of co-opting the case manager. If placed outside the organization, advocacy and brokerage needs can more easily be met but the lack of proximity of the case manager to the organization may weaken coordination of services. Are case managers salaried by the organization or are purchased services contracted outside? Is case management more effective when its functions are distributed among members of a team or when functions are unified in a role played by one individual? What is the status of the case manager and what authority do they have? Do they allocate funds? Make treatment decisions? Control client placement?

Implementation practices. Is there an optimum case load size? Does it vary according to client, provider and system needs? How often should clients be seen? Is there a relationship between caseload size and intensity of contact? Is there evidence to support more effective outcomes from more frequent or extended contact? How long will case management services be needed?

Qualifications of case managers. What level of professional training is needed to be a case manager? What skills are needed by non-professionals to perform some case management functions? Does case management for children require any training different from that needed to treat adults?

Financing. What is the cost of treatment with and without case management or with different models of case management? How do costs of case management vary by diagnosis and developmental stage? Under capitated approaches to what extent can case managers assume expected functions such as advocacy?

The final stage of research. *assessing outcomes*, investigates the effectiveness of case management interventions at client and system levels. If one were to select the broadest rubric, or the most encompassing concept to investigate, it would probably be models of case management. In the same way that psychotherapy has been researched, types of psychotherapy (e.g. cognitive versus interpersonal) are identified and contrasted, while carefully specifying the structural and process variables for each type of psychotherapy. Although clearly more complex than psychotherapy research, because of the service system factors (e.g., effect of availability of other mental health services), the notion of models that can be manualized is appealing.

Research on case management for children and adolescents and their families is timely and multifaceted. There are exciting opportunities for researchers who want to work with public sector agencies on issues that can influence the quality of life of children and families. Research will be requested as accountability is demanded for this growing mental health intervention and as policy-makers seek answers about reasonable and effective courses to take. Progress will be incremental initially as the basic parameters of case management within a continuum of care are spelled out.

Barbara J. Burns, Ph.D., *Professor of Medical Psychology, Department of Psychiatry, Developmental Epidemiology Program, Duke University Medical Center, Durham, North Carolina;* **Elizabeth Anne Gwaltney, M.A.**, *Research Assistant; and* **G. Kay Bishop, B.A.**, *Senior Data Technician, Department of Psychiatry, Developmental Epidemiology Program, Duke University Medical Center, Durham, North Carolina.*

HAVING OUR SAY

This column features responses to questions posed to readers. In this issue we feature responses from participants at the March 1992 Building on Family Strengths children's mental health case management conference to the question: "What was the most useful information you gained from your attendance at this conference?"

- Always the best part of the conference for me is informal networking. Medicaid funding, parents' perspectives!!!

- The most interesting workshop was the Parent as Case Manager. The final panel was the most interesting material/information presented throughout the conference. Judge English was a dynamic speaker. Wish there were judges like her throughout the U.S. Barbara Huff is an inspiration. More speakers with her knowledge would be helpful.

- Clear internalized understanding of what good case management is and who it serves! Families and children and not agency or public budgets.

- I am beginning to feel that professionals *do* want to work with parents.

- Enjoyed the families networking special interest meeting! Speaking to parents and hearing what their frustrations, needs, and wants are and how service providers can better serve children and families and work with them as a team.

- Creasa Reed's list of do's and don'ts in the first panel, parents' presentation with Donner, L. Behar's delineating state roles and responsibilities regarding case management.

- That there is a God that oversees us even when we think there is no hope for our children, because there is a national network and a Research and Training Center in Portland that really cares what happens to families who have children with serious disorders. That parents can be empowered and recognized as viable case managers. That we can hold states accountable for services to our children. I am grateful.

IMPLEMENTING AND MONITORING CASE MANAGEMENT: A STATE AGENCY PERSPECTIVE

During the past decade, the concept of case management has been widely discussed among child mental health professionals as the glue that holds services together for children who have serious emotional disorders and their families (1, 2). The Child and Adolescent Service System Program (CASSP) created by Congress in 1983 and administered by the National Institute of Mental Health (NIMH), promoted the development of case management services as part of the child mental health service system.

Funding through CASSP has made case management services available in some states. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 permitted states to fund targeted case management as an optional service under Medicaid. Recipients of grant funds in eight states from the Robert Wood Johnson Foundation's Mental Health Services Program for Youth initiative used grant funds to place significant emphasis on case management services.

As state mental health systems forged public policy together with funding for implementation, they assumed the responsibilities associated with the development of new concepts, that is, to ensure proper implementation and on-going support. The responsibilities include promulgating philosophy and attitude change, setting program policies and standards, providing training, ensuring funding, and monitoring and evaluating services.

CHANGING PHILOSOPHY AND ATTITUDES

To implement case management services, changes are required in: (1) attitudes about families and their role in service planning and service use; (2) attitudes about other agencies and their roles in providing quality, coordinated care and in providing entitlements; and (3) attitudes about one's own professional functioning and sharing the responsibility for service provision with others. The leadership role of the state is to communicate the reasons for such change, the positive impact change will make and the importance of effecting change.

As the family movement has gained strength through organizations such as the Alliance for the Mentally Ill and the Federation of Families for Children's Mental Health, new attitudes toward families are emerging among professionals. Professionals are revising their views of family members and recognizing that the parents of children who have emotional disorders are important partners in evoking positive change in their children and can be strong advocates for increased, appropriate services. Family strengths rather than family weaknesses have become the mainstay of treatment.

Moreover, in light of research and evaluation studies that strongly suggested that, with new treatment strategies, many children with serious disorders may be treated at home, professionals are learning to provide services in the home. The emphasis on designing services to "meet the family on its own ground" is bringing into focus the need for professionals to gain better understanding of ethnic and cultural beliefs, styles and practices in order to relate better and provide better treatment to families outside the "culture" of the clinic.

State agencies have the responsibility of encouraging local agencies to have parents participate in the service planning process and the advocacy process for their own children and broadening such participation for all children in need. Further, the state agencies have the responsibility to encourage such participation in state level activities, as well.

Children with mental health problems frequently are tied legally to multiple agencies. It makes sense that these multiple agencies work in concert to help these children and their families. Case management thus becomes a complex responsibility. On the one hand, diverse and independent agencies need to be coordinated; and, on the other hand, these agencies frequently are mandated to perform activities that incorporate some case management type functions. Thus there is a need to clarify who is mandated to do what and who is responsible for what.

Although much can be sorted out locally, the roles and responsibilities of the agencies need to be formally clarified at the state level. Initiatives that reinforce or reward joint efforts across agencies can be effective in promoting cross system understanding and in enhancing cross system communication. Further, cross training or joint training of the staff members of local agencies can be used to enhance the interagency working relationships.

In addition to the promotion of new attitudes, the multiple state agencies involved with children and families must model the kind of behaviors that reflect the new philosophy. Focusing on case management, examples should be set through: (1) the development of state-level interagency councils to address cross-agency issues, such as clarification of roles for case managers; (2) jointly sponsored, cross-agency training events; or (3) jointly funded local initiatives.

DEVELOPING STATE POLICIES AND PROCEDURES

A major responsibility of the state agency is to develop policies and procedures for implementing services that ensure the consistency of services across the state and the quality of those services. States approach this task differently. Although the quality of the policies and procedures might well be the same regardless of the mechanisms used to develop them (e.g., developed by state office alone, jointly developed with other professionals and agencies, test piloting, public hearing, etc.), it would seem that the likelihood of acceptance of a new service or a new model of service implementation would be related to the amount of ownership others assumed. As a Chinese proverb suggests, involving those affected by policies and procedures in their development may prove most satisfactory: "Tell me and I'll forget; Show me and I may remember; Involve me and I'll understand."

Substantial consensus exists among states on the definition of the target population of children with emotional disorders and upon preferred caseload size. There is less agreement, or attention to, credentials of staff, training and supervision of staff. In addition to addressing these categories, a state's plan for case management should emphasize the following: (1) the need to base service delivery on a sound model and the description of alternative models; (2) clarification of the interface of case management with other services; (3) the need for a local quality assurance/quality improvement program; (4) the program standards and mechanisms for ongoing monitoring, evaluation and feedback; and (5) the plan for impacting on the curriculum of pre-service academic programs to increase the production of professionals trained in the area of case management. Obviously the field is not without guidance concerning what is to be done, how it is to be done, where it is to be done and by whom it is to be done.

Thus the task of the state agency, hopefully in concert with representatives of other state agencies, local agencies, other providers and parents, is to review such existing information, determine its appropriateness and applicability, and modify such information to serve as the basis for state policies and procedures. In this process, it is important to develop policies, procedures, standards, rules and regulations that are clear—while at the same time—maintaining an atmosphere conducive to flexibility.

TRAINING OF STAFF

State agencies have two major responsibilities in the training arena: (1) to stimulate the relevant academic departments to revise their curriculum to include such training, both classroom-based and field-based; and (2) to ensure that appropriate in-service training and supervision are provided to professionals learning to be case managers on the job.

FINANCING CASE MANAGEMENT SERVICES

It is clearly the state's responsibility to identify financing mechanisms for services and to monitor how local programs are accessing and using funds. The emphasis on financing case management services stems from the recognition that such services seem essential to improved outcomes for children, especially children with complex problems who use the public mental health systems. State agencies have given considerable attention to financing strategies using Medicaid and through the requirements of Public Law 99-457 (early intervention services). However, the responsibility remains for state mental health agencies to identify other funds for those not eligible for Medicaid or those not under the age of six, or those not meeting the eligibility requirements of other federal entitlement programs. Other approaches to be explored include the private insurance and managed care industries that are seeking to lower service costs without sacrificing quality.

PROGRAM MONITORING AND EVALUATION

State agency monitoring or oversight of local programs is best accomplished by methods that emphasize improving functioning rather than detecting problems. It is essential to have clearly defined criteria, agreed upon by both parties and reviewed according to agreed upon methods. The monitoring should serve to identify areas where programs need to improve, where they need assistance and where the state needs to put its efforts.

The role of the state agency in the area of evaluation may perhaps best be carried out by encouraging independent studies by research institutes or by university-based professionals. Providing access for field-based research is an important contribution; this includes helping to bridge the communication gaps that may exist between those focusing on delivering services and those seeking reasonable controls in the system to carry out an evaluation.

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Lenore B. Behar, Ph.D., *Head, Child and Family Services Branch, North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services; Raleigh, North Carolina.*

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SPOTLIGHT ON THE CENTER FOR MENTAL HEALTH SERVICES' CHILD, ADOLESCENT AND FAMILY BRANCH

Gary DeCarolis, formerly Deputy Commissioner of the Vermont Department of Mental Health, has been appointed Chief of the Child, Adolescent and Family Branch, Division of Demonstration Programs, Center for Mental Health Services. Gary will have the responsibility of planning, directing, and evaluating efforts to stimulate and support demonstration programs that will contribute to the improvement and expansion of mental health services and service systems for children and adolescents with or at risk for serious emotional disorders and their families.

From 1988 until the present, Gary held the position of deputy commissioner, Vermont Department of Mental Health and Retardation where he shared the overall management responsibilities of that department with the Commissioner, and served as Director, Child, Adolescent and Family Unit, Division of Mental Health. He is very skilled in working with the Child and Adolescent Service System Program (CASSP) principles of care, having served as the director of the Vermont CASSP system where he worked to marshall the resources of the state to plan for a comprehensive community-based children's mental health system. In that capacity he was responsible for creating an interagency approach to working with children with serious emotional disorders by involving families and staff from child welfare, education, corrections, health and substance abuse systems at both the state and local levels. Gary is recognized as a national leader in developing and implementing a CASSP model of care for children in need of mental health services. In April 1993 he received an award


Gary DeCarolis

"For Excellence in Changing Public Policy to Promote WrapArounD Services" at the Second Annual WrapArounD Family Reunion in St. Charles, Illinois.

Gary has had extensive experience in the educational and human services field having been a college instructor, assistant director of a college admissions office, prison counselor, mental health counselor, and a children's mental health planner before he moved into his most recent management positions in the Vermont Mental Health and Mental Retardation system. In addition, Gary served for six years as an alderman in Burlington, Vermont where he represented low and moderate income residents. In that elected capacity he worked to protect the quality of life in an urban neighborhood and developed and implemented a comprehensive disability access plan for the wards of the city.

Gary is a strong proponent of people first language and opposes the use of abbreviations:"I dislike the use of acronyms and abbreviations. Their use really puts families at a disadvantage. I don't use them and I encourage my staff to do the same." He is the father of two children, one of whom has Down Syndrome. Gary has a master's degree in education.


Judith Katz-Leavy

Judith W. Katz-Leavy serves as Chief, Services and System Development Program; Child, Adolescent and Family Branch; Division of Demonstration Programs; Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Judy is a recognized national leader in the development, implementation and evaluation of systems of care for children and adolescents with emotional disorders and their families. The Services and System Development Program is responsible for administering the Child and Adolescent Service System Program (CASSP), a landmark national initiative that created a new model for viewing the development of integrated service systems with families as equal participants in the process. Judy is the co-founder of the CASSP program.

In addition to administering CASSP, Judy administers the Statewide Family Network Program, a program providing funds and technical assistance to family-controlled organizations to develop or expand a statewide network of information and support services available to individual family members and to family support groups, and the Comprehensive Community Mental Health Services Program for Children, a new program authorized under Public Law 102-321 (the ADAMHA Reorganization Act). This program is based on the concept of interagency collaboration and services integration—requiring individualized service planning by a multi-disciplinary team including family members and the child, unless clinically inappropriate, case management to ensure implementation of the plan, and the availability of a range of community-based mental health service options.

Judy's previous positions include serving as the evaluation coordinator of the National Institute of Mental Health's Most in Need Program; chief of the Youth Education Branch, Division of Prevention, National Institute on Alcohol Abuse and Alcoholism, Alcohol, Drug Abuse, and Mental Health Administration; and as a teacher in an early childhood learning program in the Baltimore City Department of Education. Judy has a master's degree in education.


Diane Sondheimer

Diane L. Sondheimer serves as Chief, Child and Adolescent Studies Program; Child, Adolescent and Family Branch; Division of Demonstration Programs; Center for Mental Health Services; Substance Abuse and Mental Health Services Administration. The Child and Adolescent Studies Program operates independently and in coordination with other child-serving systems, federal agencies and the private sector to ensure that mental health services to children and adolescents and their families are empirically-based. A key goal is to support research on the efficacy of innovative approaches to organizing, delivering and financing systems of care for children and adolescents with, or at risk of developing, serious emotional disorders and their families. Diane is a recognized leader in both public and private sectors as a clinician, educator, advocate, researcher, administrator and policymaker of programs designed to improve the lives of children, adolescents and their families. She has a special interest in urban and multi-cultural populations.

Diane's former positions include coordinating adolescent HIV and AIDS research for the Pediatric, Adolescent and Maternal AIDS Branch, National Institute of Child Health and Human Development within the National Institutes of Health (NIH); and serving on the faculty of the University of Maryland School of Medicine, Department of Pediatrics, Division of Adolescent Medicine for seven years. She has master's degrees in nursing and public health and is currently completing her doctorate in public policy at The American University.

WHY NOT?

Family-centered case management for children with emotional disorders addresses the needs of the family as well as the child. In this approach, case managers help families to identify, access, and coordinate supports and services that allow children to remain in their homes and enable families to live according to their own determination. A family-centered case management approach recognizes family strengths and builds on them.

Following this philosophy, the New York Office of Mental Health offers an innovative program that provides family-centered case management services to families who have children with emotional disorders and who are at risk of out-of-home placement. Family-Centered Intensive Case Management (FCIM) gives families the same kinds of resources and support that are provided to therapeutic foster care families so that children may remain in their homes. The program provides respite care, parent training and mutual self-help support groups, family and child needs assessment, case management, advocacy, and psychiatric consultation to children and their families in three rural New York counties. Unfortunately, programs such as New York's FCIM project are not available in many parts of the country. Why not expand the use of family-centered case management so that it is accessible to all families who need it? S.L.

Editor's Note: Readers are invited to submit contributions, not to exceed 250 words, for the *Why Not?* column.

We are making progress! Note the evolution from the initial "Why Not?" *column (Winter 1988* Focal Point—*below) to the current column (above).*

Therapeutic foster parents need to be paid adequately, appropriately trained, be assured of a wide range of services to meet the needs of their children, get support from professionals and from each other, and have access to respite care to provide relief from the demands and needs of the children in their homes. These services are necessary in order to recruit and keep foster parents, who often "burnout" from the demands of providing twenty-four hour care for children with serious emotional disorders.

Since the children's own families face the same demands and have the same needs as foster families, WHY NOT provide the same services and support for them while the children are still at home? We might prevent the need for out-of-home placement and we certainly would provide much needed help to families. B.J.F.

NAMI CAN SUMMER CONVENTION SCHEDULED

The National Alliance for the Mentally Ill-Child and Family Network (NAMI CAN) helps families with children who have serious brain disorders or mental illness by providing support, information, and advocacy. The purpose of the organization is to promote improved systems of care for children and adolescents with these disorders. The organization's annual convention, entitled *Advocacy for Change*, is scheduled for July 21 and 22, 1993 at the Fontainebleau Hilton in Miami Beach, Florida. A one day institute will address advocacy issues including education rights and opportunities, early intervention and the Americans With Disabilities Act. Conference topics include programming for transition services, federal advocacy issues, programs for children with neurobiological disorders and coalition building.

NAMI CAN offers a number of resources to educate families, organizations, and the general public regarding the nature of serious brain disorders and mental illness. They provide lists of helpful publications and organizations for parents with children who have children with serious brain disorders or mental illness, a series of medical information brochures that include up-to-date information on a wide variety of mental illnesses and treatment modalities, and numerous publications, videos, and other education tools. NAMI CAN also publishes a newsletter.

For conference registration or for further general information contact: NAMI CAN, 2101 Wilson Blvd., Suite 302, Arlington, Virginia 22201; (703) 524-7600 or (800) 950-NAMI.

NOTES & COMMENTS

Three Federal Grant Programs Announced

The Substance Abuse and Mental Health Services Administration (SAMHSA) has announced the availability of federal grant funds to support the development of three programs to increase the quality and availability of services for children and adolescents with emotional, behavioral, and mental disorders and their families.

The first program, the **Comprehensive Community Mental Health Services Program for Children with Serious Emotional Disturbances** (authorized by Public Law 102-321), will provide grants to states and other local governmental entities—including Indian tribes—to provide community-based services for children and adolescents with serious emotional disorders. The program will enable communities to develop local systems of care involving mental health, child welfare, education, juvenile justice, and other appropriate agencies.

Approximately $4.5 million is available in fiscal year 1993 to plan for and begin implementation of services that are currently underdeveloped or nonexistent: respite care, day treatment, therapeutic foster care, intensive home-based, school or clinic-based services, emergency services, and diagnostic and evaluation services. Each child will have an individualized service plan developed with the participation of family and, where appropriate, the child. The plan will designate a case manager to assist the child and family by coordinating services among multiple systems. The program will be administered by SAMHSA's Center for Mental Health Services (CMHS). ***Completed grant applications are due on or before July 16, 1993.***

CMHS will also administer the **Mental Health Services Demonstration Grants for Statewide Family Networks.** This grant program was initiated to provide support to family-controlled organizations for the development and expansion of statewide networks offering support and information to children and their families. Under the program, family-controlled organizations will provide assistance and disseminate information to individual family members and family groups throughout the United States. Approximately $1.3 million dollars are available in fiscal year 1993 to support 20-25 projects and the average award is expected to be $50,000 per year for a three year period. Awards are limited to one per state. ***Completed grant applications are due on or before July 30, 1993.***

Similarly, CMHS will administer the **Child and Adolescent Service System Program (CASSP) Infrastructure Development Demonstration Grants.** This program is an effort to assist states in moving state-level system improvement activities to the local level. This program is intended to demonstrate the efficacy of various approaches to infrastructure organization and to lay the foundation for comprehensive, coordinated, community-based services to children and adolescents with serious emotional disorders. Approximately $1.9 million will be available in fiscal year 1993 to support ten to twelve projects. The expected average amount of each award will be approximately $175,000 per year for a three year period. Each state or territory may submit one application. ***Completed grant applications are due on or before July 30, 1993.***

Grant application kits for each of the above programs may be obtained from: Steve Hudak, Grants Management Officer, Center for Mental Health Services, Room 7C-23, 5600 Fishers Lane, Rockville, Maryland 20857; (301) 443-4456.

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Interprofessional Education Project Seeks Nominations of Interdisciplinary Programs

The Interprofessional Education Project at the Research and Training Center on Family Support and Children's Mental Health is engaged in a study of education and training programs around the country that are family-centered and that exemplify one or more of the following principles: (1) interagency collaboration; (2) interprofessional collaboration; (3) family-professional collaboration; (4) cultural competence; and (5) community-based services.

We are seeking nominations of programs that incorporate these principles, particularly those that provide interdisciplinary or interprofessional learning opportunities. We will conduct a telephone and written survey of all nominated programs to find out about course content, target population, and educational methods. Our objectives are to locate, develop and disseminate interdisciplinary training materials that promote parent-professional and interprofessional/interagency collaboration in children's mental health. If you know of any program(s) that meet our criteria, please call or write a note including the name, address and telephone number of the program, and, if possible, the name of a contact person. Please provide nominations to: Pauline Jivanjee, Project Manager, Interprofessional Education Project, Research and Training Center on Family Support and Children's Mental Health, Portland State University, P.O. Box 751, Portland, Oregon 97207-0751; (503) 725-5197.

Portland Research and Training Center Schedules Spring 1994 Conference and Issues Call for Papers

The Research and Training Center on Family Support and Children's Mental Health will sponsor a national conference, ***Building on Family Strengths: Research, Advocacy, and Partnership in Support of Children and Their Families, April 10-12, 1994,*** in Portland, Oregon. This conference is a forum for the examination and dissemination of state-of-the art research findings and issues in the areas of family support and family-centered care. The conference is divided into four tracks: Developments in Family Research Methods; Family Member/Consumer Involvement; Research on Family Support Services; and Recognizing Family Diversity.

The conference is intended to bring together family members, researchers policy-makers, service providers, and advocates interested in strengthening research and practice in response to the needs of children and families. The conference will provide an opportunity for participants to disseminate findings and innovations in family research.

Proposals are invited in the form of paper presentations, poster sessions or symposia. Preference will be given to abstracts that report on research results. For submission applications, general conference registration materials, or further information please contact Richard Hunter at the Research and Training Center on Family Support and Children's Mental Health, Portland State University, P.O. Box 751, Portland, Oregon 97207-0751; (503) 725-4040.

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Seventh Annual Children's Mental Research Conference Scheduled

The Research and Training Center for Children's Mental Health has scheduled its seventh annual research conference, ***A System of Care for Children's Mental Health: Expanding the Research Base***. The conference will be held ***February 28-March 2, 1994*** at the Hyatt Regency Westshore in Tampa, Florida. Proposals and abstracts for presentations addressing longitudinal research, systems-level interventions, outcome evaluations of children with serious emotional disorders and their families, and policy development/change initiatives are invited. The deadline for submission is October 15, 1993. To request a submission form, contact Dr. Krista Kutash, Deputy Director, Research and Training Center for Children's Mental Health, Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd., Tampa, Florida 33612; (813) 974-4661 or (813) 974-4657.

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CASSP Training Institutes Planned for June 1994

An important upcoming event will provide an intensive training opportunity for a wide range of participants. The biannual ***Child and Adolescent Service System Program (CASSP) Training Institutes*** are scheduled for ***June 19-23, 1994*** and will be held in Traverse City, Michigan at the Grand Traverse Resort.

The response to the 1992 Training Institutes, held in Colorado, was overwhelming and confirmed an extraordinary level of interest in training related to the development of systems of care. To meet this need, the 1994 Training Institutes will focus on *Developing Local Systems of Care for Children and Adolescents with Severe Emotional Disturbances* and will offer an opportunity to obtain in-depth, practical information on how to develop, organize and operate comprehensive, coordinated, community-based systems of care for children and their families. The faculty will be comprised primarily of representatives of communities that have made substantial progress toward developing systems of care, and participants will be able to choose Institutes presenting different approaches to system development.

The Institutes are designed for a variety of individuals including state and local administrators, planners, providers, parents, and advocates. A primary target group consists of agency administrators, managers, providers, and parents from local areas, representing mental health and other child-serving agencies. These individuals, ideally attending as a team, are the ones who can take the knowledge and skills developed at the Institutes and begin to apply it in their home communities. This training can be an invaluable experience for a community that is planning a system improvement initiative. This early announcement is intended to allow sufficient lead time to organize delegations and make arrangements to attend.

The Institutes are sponsored by the CASSP Technical Assistance Center at Georgetown University and are funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. For more information contact the CASSP Technical Assistance Center at 2233 Wisconsin Avenue, N.W., Washington, D.C. 20007; (202) 338-1831.

NOTES & COMMENTS

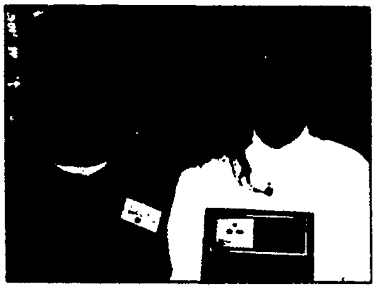
Fourth Annual Meeting of the Federation of Families for Children's Mental Health Held


Naomi Karp

Approximately 300 family members and professionals attended *New Visions-New Partners: Advocacy, Involvement, and Strategies*, the fourth annual meeting of the Federation of Families for Children's Mental Health. Held in Arlington, Virginia on November 21 and 22, 1992, the conference workshops addressed the issues of early intervention, elementary education, transition from school to work, juvenile justice, and custody relinquishment.

Over 95 percent of those who attended the meeting were family members, and day care was provided for 30 children whose relatives participated in the conference. Many families were able to attend as they received scholarships provided by the Substance Abuse and Mental Health Services Administration and dispersed through the Child and Adolescent Service System Program Technical Assistance Center. People of color constituted 25-30 percent of those in attendance.

One highlight of the conference was a report on the Mental Health Initiative for Urban Children project by the Annie B. Casey Foundation. Communities in Massachusetts, Florida, Virginia, Texas, Illinois, and Colorado have been chosen to receive grants to develop healthier neighborhoods, families and children. The grant money will be used to expand and create new services, and for training to fill in service gaps and maintain children in their neighborhoods. The Initiative addresses issues of jobs, safety, violence prevention, and after-school programs. Over three million dollars will be granted to each state.


Barbara Friesen and Barbara Berlin

Several honors and awards were presented. The "Claiming Children" award went to Barbara Berlin of Louisiana, who responded, "I keep my eye on the vision. Our voices will be heard and our children treated properly." Naomi Karp received a special gift of honor for her "vision and values," which have become the foundation of the Federation. Barbara Friesen received the "Professional of the Year" award and was honored for her "honesty, creativity and integrity."

◆

New Publications Available Through Research and Training Center's Resource Service

Five new publications are available through the Research and Training Center's Resource Service. The results of a nationwide study of professional training curricula in schools of social work, psychiatric nursing, clinical psychology, special education, and child psychiatry are described in *Parent-Professional Collaboration Content in Professional Education Programs: A Research Report.* The report includes descriptions of individual programs, specific courses, and in some cases, published materials provided by faculty in response to requests for parent-professional curriculum materials.

One hundred thirty-six entries are contained in a second new publication entitled *Annotated Bibliography: Collaboration Between Professionals and Families of Children with Serious Emotional Disorders.* The topics addressed include the need for family-professional collaboration, guidelines for the establishment of collaborative relationships, collaboration in early intervention and educational systems, advocacy, and empowerment.

A model of family caregiving is presented in *Building a Conceptual Model of Family Response to a Child's Chronic Illness or Disability*. With the intent of informing family-centered research for families and children with emotional disorders, the model synthesizes the findings of psychological and sociological literature to identify the causal antecedents, mediating processes, and adaptational outcomes of families coping with the challenges of caring for children with emotional disorders.

Recommendations for developing a family research and demonstration agenda for children's mental health are reported in the *Family Research Demonstration Symposium Report.* This report is a result of a working meeting held in 1992 and sponsored by the Research and Training Center in collaboration with the Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. The document outlines the suggestions of work groups who discussed prominent issues and developments in four areas of family research: parent-professional collaboration, training, and systems change; family support and advocacy; multicultural competence; and financing family support options and services.

The third edition of the *National Directory of Organizations Serving Parents of Children and Youth with Emotional and Behavioral Disorders* is now available. While the second edition contained 344 organizations, the third edition contains 612 entries. The directory offers information on parent organizations nationwide that provide education and information, parent training, advocacy, support groups, transition services, and direct assistance to parents. A wide range of organizational types are listed, including self-help organizations coordinated by and for parents with no professional involvement, groups started by staff members of service-providing agencies, and groups sponsored by other organizations such as mental health associations.

Ordering information is provided on page 19.

◆

Four New Journals on Family Research Available

The *Journal of Child and Family Studies* focuses on identifying, treating, and rehabilitating children and adolescents with emotional disorders, and presents family studies from a mental health perspective. This international quarterly journal is directed toward scholars, researchers, and practitioners, and covers such topics as child abuse and neglect, respite care, foster care, financing mental health care, and family stress. The format includes articles, book and media reviews, commentaries, and professional announcements. For more information, contact: Nirbhay N. Singy, Editor, Department of Psychiatry, Medical College of Virginia, P.O. Box 489, Richmond, Virginia, 23298; (804) 786-4393.

The *Journal of Emotional and Behavioral Disorders* (JEBD) is an international, multidisciplinary journal featuring articles on research, practice, and theory related to individuals with emotional and behavioral disorders and to the professionals who serve them. JEBD publishes original research reports, reviews of research, descriptions of practices and programs, and discussions of key issues in the field. Topics focus on: characteristics, evaluation, intervention, assessment, and legal or policy issues. For additional information contact: Michael H. Epstein & Douglas Cullinan, Editors, PRO-ED Journals, 8700 Shoal Creek, Austin, Texas, 78758-6897; (512) 451-3246.

The *Journal of Emotional and Behavioral Problems* is an interdisciplinary journal directed at policy leaders and practitioners who work with children in conflict. With a mission to revalue children and combine research with practice, the journal addresses such topics as gangs, education, and empowering children and families. Each issue contains regular features spotlighting the perspectives of children, problems and stresses placing youth at risk, innovative programs, global challenges for youth development, and life space interviewing for resolving conflict. For more information, contact: Nicholas Long & Larry Brendtro, Editors, Nancy R. Shin, Director of Publications, National Education Service, 1610 West 3rd Street, P.O. Box 8, Bloomington, Indiana, 47402; (812) 336-7700.

A forthcoming publication, the *Journal of Community Practice: Organizing, Planning, Development and Change*, will provide a much needed publication forum for articles on community organizing, planning, research, development, policy and social change. The journal will emphasize empirical and theoretical articles and case studies focused on processes of organizing, social planning, policy analysis, social and economic development and social change. Additional information may be obtained from the following: Marie Weil, Editor, School of Social Work, University of North Carolina, Chapel Hill, 223 E. Franklin Street, CB #3550, Chapel Hill, North Carolina 27599-3550; (919) 962-1225.

◆

Family Research Symposium Held

The Research and Training Center on Family Support and Children's Mental Health held a small working meeting on November 22-24, 1992 entitled, *Family Symposium: Developing a Research and Demonstration Agenda for Services in Children's Mental Health.* The purposes of the symposium were to identify the current state of knowledge regarding family issues in children's mental health, develop recommendations for areas of future investigation, and identify ways to encourage investigation in the area of family-related research.

The working sessions began with presentations about the historical roots, dominant constructs, and research approaches that have characterized family research in other fields. Meeting participants then used a similar format to generate information on children's mental health and identify four areas in need of further development: (1) professionals and systems: parent-professional collaborations and training systems; (2) family support and family advocacy; (3) multicultural competence; and (4) financing of family support and family-centered services. Work groups then generated recommendations for building a research agenda.

The results of the meeting are now available in a new document, the *Family Research and Demonstration Symposium Report*. For ordering information, see page 19.

Research and Training Center Resource Materials

☐ NEW! *Annotated Bibliography. Collaboration Between Professionals and Families of Children with Serious Emotional Disorders.* Contains 136 entries addressing family-professional collaboration, establishing collaborative relationships, collaboration in early intervention and education, advocacy, and empowerment. $6.00.

☐ *Annotated Bibliography. Parents of Emotionally Handicapped Children: Needs, Resources, and Relationships with Professionals.* Covers relationships between professionals and parents, parent self-help, support groups, parent participation. $7.50.

☐ *Annotated Bibliography. Youth in Transition: Resources for Program Development and Direct Service Intervention.* Transition needs of adolescents: educational and vocational issues, programs and curriculum, research overviews, interpersonal issues, skills training. $6.00.

☐ *Brothers and Sisters of Children with Disabilities: An Annotated Bibliography.* Addresses the effects of children with disabilities on their brothers and sisters, relationships between children with disabilities and their siblings, services and education for family members. $5.00.

☐ NEW! *Building a Conceptual Model of Family Response to a Child's Chronic Illness or Disability.* Proposes comprehensive model of family caregiving based on literature review. Causal antecedents, mediating processes and adaptational outcomes of family coping considered. $5.50.

☐ *Changing Roles, Changing Relationships: Parent-Professional Collaboration on Behalf of Children With Emotional Disabilities.* Monograph examines barriers to collaboration, elements of successful collaboration, strategies for parents and professionals to promote collaborative working relationships, checklists for collaboration, suggested resources. $4.50.

☐ *Child Advocacy Annotated Bibliography.* Includes selected articles, books, anthology entries and conference papers. $9.00.

☐ *Choices for Treatment: Methods, Models, and Programs of Intervention for Children With Emotional Disabilities and Their Families. An Annotated Bibliography.* Literature on the range of therapeutic interventions used with children and adolescents with emotional disabilities is described. Includes innovative strategies and programs. $6.50.

☐ *Developing and Maintaining Mutual Aid Groups for Parents and Other Family Members: An Annotated Bibliography.* Topics addressed include organization and development of parent support groups and self-help organizations, professionals' roles in self-help groups, parent empowerment in group leadership, and group advocacy. $7.50.

☐ *Families as Allies Conference Proceedings: Parent-Professional Collaboration Toward Improving Services for Seriously Emotionally Handicapped Children and Their Families.* April 1986. Delegates from thirteen western states. Includes: agenda, presentation transcriptions, recommendations, worksheets, and evaluations. $9.50.

☐ NEW! *Family Research and Demonstration Symposium Report.* Summarizes recommendations from 1992 meeting for developing family research and demonstration agenda in areas of parent-professional collaboration and training systems, family support and advocacy, multicultural competence, and financing. $7.00.

☐ *Gathering and Sharing: An Exploratory Study of Service Delivery to Emotionally Handicapped Indian Children.* Findings from Idaho, Oregon, and Washington, covering current services, successes, service delivery barriers, exemplary programs and innovations. $4.50.

☐ *Glossary of Acronyms, Laws, and Terms for Parents Whose Children Have Emotional Handicaps.* Glossary excerpted from *Taking Charge.* Approximately 150 acronyms, laws, and words and phrases commonly encountered are explained. $3.00.

☐ *Interagency Collaboration: An Annotated Bibliography for Programs Serving Children With Emotional Disabilities and Their Families.* Describes local interagency collaborative efforts and local/state efforts. Theories of interorganizational relationships, evaluations of interagency programs, and practical suggestions for individuals contemplating joint programs are included. $5.50.

☐ *Issues in Culturally Competent Service Delivery: An Annotated Bibliography.* Perspectives on culturally-appropriate service delivery; multicultural issues; culturally specific African-American, Asian-American/Pacific Islander, Hispanic-Latino American, Native American sections. $5.00.

☐ *Making the System Work: An Advocacy Workshop for Parents.* A trainers' guide for a one-day workshop to introduce the purpose of advocacy, identify sources of power and the chain of command in agencies and school systems, and practice advocacy techniques. $8.50.

☐ *The Multnomah County CAPS Project: An Effort to Coordinate Service Delivery for Children and Youth Considered Seriously Emotionally Disturbed.* Process evaluation of an interagency collaborative effort. The planning process is documented and recommendations are offered. $7.00.

☐ NEW! *National Directory of Organizations Serving Parents of Children and Youth with Emotional and Behavioral Disorders, Third Edition.* Includes 612 entries describing organizations that offer support, education, referral, advocacy, and other assistance to parents. $12.00.

☐ *Next Steps: A National Family Agenda for Children Who Have Emotional Disorders Conference Proceedings.* December 1988. Includes: development of parent organizations, building coalitions, family support services, access to educational services, custody relinquishment, case management. $6.00.

☐ *Next Steps: A National Family Agenda for Children Who Have Emotional Disorders (booklet).* Briefly summarizes Next Steps Conference and recommendations made by work groups. Designed for use in educating administrators, policymakers and advocates about children's mental health issues. Single copy: $2.50. Five Copies: $7.00

☐ *Organizations for Parents of Children Who Have Serious Emotional Disorders: Report of a National Study.* Results of study of 207 organizations for parents of children with serious emotional disorders. Organizations' activities, program operation issues, training programs described. $4.00.

☐ NEW! *Parent-Professional Collaboration Content in Professional Education Programs: A Research Report.* Results of nationwide survey of professional programs that involve parent-professional collaboration. Includes descriptions of individual programs. $5.00.

☐ *Parents' Voices: A Few Speak for Many* (videotape). Parents of children with emotional disabilities discuss their experiences related to seeking help for their children (45 minutes). A trainers' guide is available to assist in presenting the videotape. Free brochure describes the videotape and trainers' guide and provides purchase or rental information.

☐ *Respite Care: A Key Ingredient of Family Support.* Conference proceedings. October 1989. Includes speeches and panel presentations on topics such as starting respite programs, financing services, building advocacy, and rural respite care. $5.50.

☐ *Respite Care: An Annotated Bibliography.* Issues discussed include: the rationale for respite services, family needs, program development, respite provider training, funding, and program evaluation. $7.00.

☐ *Respite Care: A Monograph.* Monograph describes: types of respite care programs, recruitment and training of providers, benefits of respite services to families, respite care policy and future policy directions, and a summary of funding sources. $4.50.

☐ *Statewide Parent Organization Demonstration Project Final Report.* Describes and evaluates the development of statewide parent organizations in five states. $5.00.

☐ *Taking Charge: A Handbook for Parents Whose Children Have Emotional Handicaps.* Addresses issues such as parents' feelings about themselves and their children, labels and diagnoses, and legal issues. Second edition includes post-traumatic stress disorder and mood disorders such as childhood depression and bipolar disorder. $7.00.

☐ *Therapeutic Case Advocacy Trainers' Guide: A Format for Training Direct Service Staff and Administrators.* Addresses interagency collaboration among professionals in task groups to establish comprehensive systems of care for children and their families. $5.75.

☐ *Therapeutic Case Advocacy Workers' Handbook.* Companion to the *Therapeutic Case Advocacy Trainers' Guide.* Explains the Therapeutic Case Advocacy model, structure of task groups, group process issues, evaluations. $4.50.

☐ *Transition Policies Affecting Services to Youth With Serious Emotional Disabilities.* Examines how state level transition policies can facilitate transitions from the child service system to the adult service system. Elements of a comprehensive transition policy are described. Transition policies from seventeen states are included. $8.50.

☐ *Working Together: The Parent/Professional Partnership.* A trainers' guide for a one-day workshop for a combined parent/professional audience. Designed to identify perceptions parents and professionals have of each other and obstacles to cooperation; as well as discover the match between parent needs and professional roles, and practice effective listening techniques and team decision making. $8.50.

☐ *Youth in Transition: A Description of Selected Programs Serving Adolescents With Emotional Disabilities.* Descriptions of existing youth transition programs provided. Residential treatment, hospital and school based, case management, and multi-service agency transition programs are included. $6.50.

☐ *List of Other Publications Available Through the Research and Training Center. Free.*

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