KEY COMPONENTS OF SUCCESSFUL TREATMENT PROGRAMS

Integrated Programming – The "Systems" Approach
Screening and Assessment
Individualized Care Planning
Discharge Planning
Engaging Families in Treatment
Culturally-Competent Service Delivery
Psychosocial and Pharmacological Treatments

While studies have identified numerous strategies and techniques that are effective in the treatment of mental health issues, a growing body of research shows that there are several guiding principles that provide a foundation for any treatment program. These principles will be discussed in detail in the following paragraphs.

Integrated Programming – The "Systems" Approach

Research continues to support the idea that the mental health needs of children and adolescents are best served within the context of a "system of care" in which multiple service providers work together in an organized, collaborative way. The system-of-care approach encourages agencies to provide services that are child-centered and family-focused, community-based, and culturally competent. The guiding principles also call for services to be integrated. Linking child-serving agencies and programs allows for collaborative planning, development, and implementation of services. Additional information on systems of care is provided in the "Role of the Family" section.

Systems of care produce important system improvements. For example, studies have shown that systems of care improve the functional behavior of children and reduce the use of residential and out-of-state placements. Parents also appear to be more satisfied with services provided within systems of care than with more traditional service delivery systems.

The Virginia Department of Behavioral Health and Developmental Services (VDBHDS) emphasizes the need for agency collaboration at both the state and local levels (2004). This can be achieved by promoting integration of services and establishing policies that require service providers to conduct a single, comprehensive intake addressing the areas of mental health, intellectual disability, and substance abuse. Moreover, community partnerships can be strengthened or enhanced to improve the delivery of child and adolescent mental health services.

Screening and Assessment

Comprehensive assessment, screening, and evaluation are necessary for children and adolescents experiencing a mental health crisis. Children should also be screened to identify potential delayed or atypical development, thus determining the appropriate level of assessment (Pires, 2002). In addition to screening, assessment and evaluation collectively address the needs and services of the child and family (Pires).

Parents of youth who are identified with a possible problem should be offered a full assessment by a professional clinician. A qualified mental health professional can determine whether a comprehensive

psychiatric evaluation for serious emotional behavior problems is necessary (American Academy of Child & Adolescent Psychiatry [AACAP], 2005). Such a step will lead to accurate assessment and, if needed, appropriate, individualized treatment. In addition, every step of the assessment process must include parental consent and youth assent (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011).

Individualized Care Planning

In order to make certain that there is a continuity of treatment, a framework should be established that ensures that a child can transition with ease from one service to another. The efficiency of these transitions is enhanced through the creation of effective individualized service plans. These plans, which are targeted to the child's specific needs, identify problems, establish goals, and specify appropriate interventions and services. Developed in partnership with the child and family, an individualized service plan allows for services to be matched with the unique potential and needs of each child and family (Stroul & Friedman, 2011).

Once screening and assessment have taken place, an individual care plan ensures that the distinct needs of the child are met. The goal is to plan and provide appropriate services and supports to the child. Elements that must be acknowledged include building trust, engaging the family, and tailoring family supports (Pires, 2002). Some components to be included in such a plan are:

- Background information and family assessment
- Identifying information
- Child development and behavior
- Needs
- Family functioning style
- Social support network
- Safety issues and risks
- Goals
- Sources of support and/or resources
- Action plan
- Progress evaluation

Discharge Planning

Service providers have found that a breakdown in the system of care is frequently encountered in the area of discharge planning. A discharge plan should be created whenever a child is transitioning from inpatient or residential treatment back into the community. These plans should be updated in consultation with the child's family before the child is released from treatment. They should describe the therapy and services that were provided in the facility and recommend any necessary follow-up services, which should then be coordinated by a case manager. Although they are frequently overlooked, discharge plans are a key component of a comprehensive system of care, as they help to ensure that the gains made in an inpatient or residential setting are continued once the child returns to the community.

Engaging Families in Treatment

Service providers and researchers have increasingly realized the important role that families play in the treatment of children with mental health disorders. The mental health system has taken steps to make families partners in the delivery of mental health services for children and adolescents (U.S. Department of Health and Human Services, 1999). For further discussion of the roles that families should play in treatment services, see the "Role of the Family in Treatment Programs" section of the *Collection*.

Engagement involves the participation of people who both deliver and seek services. With effective engagement, the likelihood of ongoing participation in services and supports increases (National Alliance on Mental Illness [NAMI], 2016). When care is respectful, compassionate, and centered on an individual's life goals, the likelihood of recovery is sharply increased.

According to the New Freedom Commission on Mental Health established by President George W. Bush, local, state, and federal officials must engage families in planning and evaluating treatment and support services (2003). The direct participation of families in developing a range of community-based, recovery-oriented treatment and support services is important. Families of children with serious emotional disturbances have a key role in mental health care delivery in that they can advocate for a system that focuses on recovery through the use of appropriate evidence-based treatments.

The New Freedom Commission also specifies that mental health care should be consumer and family driven. Consumers their families should be encouraged to be fully involved in care, which will help promote a recovery-based mental health system. Families can take part in this process by becoming educated about the appropriate treatments for their child, as well as the provider qualifications necessary to delivery these treatments. For more information about mental health providers' qualifications, please see the "General Description of Providers" section of the *Collection.*

Culturally-Competent Service Delivery

Virginia, like the nation as a whole, is becoming more racially diverse. The minority share of the population has increased from 29.8 percent in 2000 to 35.2 percent in 2010 (Sturtevant, 2011). During this period, the biggest gain was among Virginia's Hispanic population, which grew by more than 300,000, or 92 percent (Cai, 2011). The Asian population grew by 68.3 percent, and the population of all other minority races (including persons of two or more races) grew by 50.8 percent (Sturtevant). This increase in diversity has significant implications for service providers in the Commonwealth, as cultural factors are becoming increasingly important in the evaluation and treatment of mental health disorders.

Culture has been found to influence many aspects of mental health disorders. Individuals from specific cultures may express and manifest their symptoms in different ways. They may also differ in their styles of coping, their use of family and community supports, and their willingness to seek and continue treatment. Moreover, clinicians may be influenced by their own cultural values, which may affect diagnosis, treatment, and service delivery decisions (U.S. Department of Health and Human Services, 2001).

The variability within a culture and among different cultural groups is described in Table 1.

The following is attributed to Kumpfer and Alvarado (1998). Cultural competency involves addressing the various folkways, mores, traditions, customs, rituals, and dialects that are specific to each culture and ethnicity (Saldana, 2001). Research has shown that tailoring interventions to the cultural traditions of the family improve outcomes. Culturally-relevant values can be integrated into existing model programs for a variety of ethnic groups. Such an approach can address the various nuances that cultures may exhibit, such as specific values and beliefs. These cultural beliefs should be incorporated into an organized, culturally sensitive treatment framework.

Cultural differences may also affect the success of mental health services. The mental health treatment setting relies significantly on language, communication, and trust between patients and providers. In addition, children may be reticent to share elements of their cultural orientation with persons who do not share their culture. Therefore, therapeutic success may hinge on the clinician's ability to understand a patient's identity, social supports, self-esteem, and perception of stigma. Consequently, mental health service providers must recognize underlying cultural influences so they can effectively address the mental health needs of each segment of the community (U.S. Department of Health and Human Services, 1999).

Table 1
Addressing Cultural Variability

Variability Factor	Description
Acculturation	This reflects the extent to which a person is familiar with and proficient within U.S. mainstream culture.
Poverty	There may be difference in resources, as well as a lack of awareness of traditional mental health interventions and the importance of compliance.
Language	Clients may not be as fluent in English as they are in their native language. Different dialects within the same language may also create communication barriers.
Transportation, housing and childcare	A lack of available resources and supports may interfere with access to treatment and adherence with provider expectations.
Reading ability/ educational background	Individuals may vary substantially in academic experience. This is true within ethnic subgroups, as well as between subgroups.
Beliefs	People from diverse cultures vary in their beliefs about what is considered "illness," what causes an illness, what should be done to address an illness, and what the treatment outcome should be. Providers cannot assume their clients' views match theirs.
Physical characteristics	People of different ethnic backgrounds sometimes differ in their appearance, even within the same ethnic group.

Source: Saldana, 2001.

Culturally competent treatment programs are founded upon an awareness of and respect for the values, beliefs, traditions, customs, and parenting styles of all individuals who reside in the community. Providers should be aware of the impact of their own culture on the therapeutic relationship with their clients and consider these factors when planning and delivering the services for youth and their families. Ideally, culturally competent programs include multilingual, multicultural staff and provide extensive community outreach (Cross et al., 1989).

The services offered within a community should also reflect a respect for cultural diversity. For example, the inclusion of extended family members in treatment efforts should be incorporated within certain treatment approaches, when appropriate. It would also be beneficial for mental health agencies to display culturally relevant pictures and literature in order to show respect and increase consumer comfort with services. Finally, agencies should consider the holidays or work schedules of consumers when scheduling office hours and meetings (Cross et al., 1989).

Cultural differences other than ethnicity must also be considered. For example, Americans living in isolated and impoverished rural areas may display unique characteristics that present barriers to mental health services. Some may not seek care because of a perceived stigma attached to mental health disorders, a lack of understanding about mental illnesses and treatments, a lack of information about where to go for treatment, or an inability to pay for care. Furthermore, factors such as poverty and geographic isolation may affect the quality of mental health care available to these individuals. These issues are further complicated by the limited availability of mental health specialists, such as psychiatrists, psychologists, psychiatric nurses, and social workers, in rural areas (National Institute of Mental Health [NIMH], 2000).

It is important to consider the impact of culture on mental health service delivery. Culturally competent programming has been found to promote service utilization for all ages, including children (Snowden & Hu, 1997). Furthermore, children and families enrolled in mental health programs that are aligned with a community's culture are less likely to drop out of treatment than those in mainstream programs (SAMHSA, 2014; Takeuchi, Sue, & Yeh, 1995). Culturally competent training and service planning serve as important components of the mental health delivery system.

Psychosocial and Pharmacological Treatments

Because of the increasing recognition of the impact mental health disorders have upon children and adolescents, there has been greater scrutiny regarding the effectiveness and safety of mental health interventions used to treat children. Accordingly, the number of scientific studies of treatment effectiveness has risen dramatically. Several federally sponsored clinical trials have been conducted to address the effectiveness of interventions for childhood disorders (American Psychological Association [APA], 2006).

Child and adolescent mental health treatments may be psychosocial, pharmacological, and/or combined. Psychosocial treatments are treatments that include different types of psychotherapy and social and vocational training. These interventions aim to provide support, education, and guidance to children with mental health conditions (NAMI, 2015). Pharmacological treatments use medication to treat the mental health disorder.

The APA's working group on psychotropic medications recommends that, for most children and adolescents, psychosocial interventions should be considered first (APA, 2006). The working group noted a variety of reasons why psychosocial interventions were preferred, with the primary reason being that these interventions are safer than psychotropic medications (APA). There are vast developmental differences in child and adolescent populations that influence physiological, cognitive, behavioral, and affective functioning. Development also has implications with respect to medication management. For instance, physiological differences can result in markedly different rates of medication absorption, distribution in the body, and metabolism among youth of different ages and stages of development (Brown & Sammons, 2002, as cited by APA). Children are also less able than adults to accurately describe changes in their physiological and psychological functioning, the course of these changes over time, and any adverse effects of psychotropic medications. In addition, parents are responsible for both the decision to use pharmacotherapy and the administration of medication. In the school setting, it may be the school nurse or the teacher who administers medication. As a result, parents' and school personnel's attitudes toward medication may influence whether a child adheres to medical regimens. For these reasons, the unique issues in child and adolescent psychopharmacology must be considered when prescribing and monitoring medication in pediatric populations (APA).

If medication is recommended as a treatment, the physician recommending its use should be experienced in treating psychiatric illnesses in children and adolescents (AACAP, 2012). He or she should fully explain the reasons for medication use, the benefits the medication should provide, the possible risks and adverse effects, and any other treatment alternatives. When pharmacological treatments are necessary, their use should be carefully monitored, and dosage should be tapered off as soon as possible (Tweed et al., 2012). In addition, psychiatric medication should not be used alone. The use of medication should be based on a comprehensive psychiatric evaluation and be one part of a comprehensive treatment plan.

References

American Academy of Child & Adolescent Psychiatry (AACAP). (2005). *Facts for families: Comprehensive psychiatric evaluation*. Retrieved from http://www.aacap.org/App_Themes/AACAP/docs/facts_for_families/52_comprehensive_psychiatric_evaluation.pdf

American Academy of Child & Adolescent Psychiatry (AACAP). (2012). Psychiatric medication for children and adolescents: Part I – How medications are used. No. 21. Retrieved from http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Psychiatric-Medication-For-Children-And-Adolescents-Part-I-How-Medications-Are-Used-021.aspx

American Psychological Association (APA). (2006). Report of the working group on psychotropic medications for children and adolescents: Psychopharmacological, psychosocial, and combined interventions for childhood disorders: Evidence base, contextual factors, and future directions. Washington, DC: Author.

Cai, Q. (2011). A decade of change in Virginia's population, *The Virginia News Letter, 87*(4), Retrieved from http://www.coopercenter.org/sites/default/files/publications/Virginia%20News%20Letter%202011%20Vol.%2087%20No%204.pdf. *Not available December 2017.*

Cross, T., Dennis, K., Isaacs, M., & Bazron, B. (1989). *Towards a culturally competent system of care*, National Technical Assistance Center for Children's Mental Health at Georgetown University, Washington, DC.

Kumpfer, K., & Alvarado, R. (1998). Effective family strengthening interventions. *Juvenile Justice Bulletin.* Office of Juvenile Justice and Delinquency Prevention.

National Alliance on Mental Illness (NAMI). (2016). Engagement: A new standard for mental health care. Retrieved from https://www.nami.org/engagement

National Alliance on Mental Illness (NAMI). (2015). Psychosocial treatments fact sheet. Retrieved from http://www.namidupage.org/wp-content/uploads/2015/05/Psychosocial-Treatments-Fact-Sheet.pdf

National Institute of Mental Health (NIMH). (2000). *Fact sheet: Rural mental health research at the National Institute of Mental Health.* Retrieved from http://www.nimh.nih.gov/publicat/ruralresfact.cfm. *Not available December 2017.*

Pires, S. (2002). *Building systems of care: A primer.* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. Collaborative.

President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America.* DHHS Pub. No. SMA-03-3832. Rockville, MD: Author.

Saldana, D. (2001). Cultural competency, a practical guide for mental health service providers. *Hogg Foundation for Mental Health.* The University of Texas at Austin.

Snowden, L., & Hu, T. (1997). Ethnic differences in mental health services among the severely mentally ill. *Journal of Community Psychology, 25*, 235-247.

Stroul, B. A., & Friedman, R. M. (2011). Effective strategies for expanding the system of care approach. A report on the study of strategies for expanding systems of care. Atlanta, GA: ICF Macro.

Sturtevant, L. (2011). Virginia's changing demographic landscape. *Virginia Issues & Answers.* Retrieved from https://www.jmu.edu/lacs/_files/Virginias-Changing-Demographic-Landscape.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2011). *Identifying mental health and substance use problems of children and adolescents: A guide for child-serving organizations.* HHS Publication No. SMA 12-4670. Rockville, MD.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). Improving cultural competence. Treatment Improvement Protocol (TIP) Series No. 59. HHS Publication No. SMA 14-4849. Rockville, MD.

Takeuchi, D., Sue, S., & Yeh, M. (1995). Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. *American Journal of Public Health, 85*, 638-643.

Tweed, L., Barkin, J.S., Cook, A., & Freeman, E. (2012). A weighty matter: Anti-psychotic medications for children and youth should be chosen carefully and used only as long as needed. Maine Independent Clinical Information Service

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD.

U.S. Department of Health and Human Services. (2001). Mental health: Culture, race, ethnicity—Supplement to mental health: Report of the Surgeon General. Rockville, MD: Author.

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (VDBHDS). (2004). Final report and recommendations to the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Restructuring Policy Advisory Committee. Retrieved from http://www.dmhmrsas.virginia.gov/documents/CFS-ChildrensSpecialPopulationReport.pdf. *Not available December 2017*.