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Moving from Principles to Practice: Recommended Policy Changes to Promote Family-Centered Care

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Abstract

This paper emphasizes the value of family-centered care. Discussion highlights family-centered philosophies (e.g., Systems of Care [SOCs]) and practice models (i.e., wraparound) and identifies discrepancies between conceptualizations and actual practice. Data from multiple sources detail issues in fidelity to family-centered values and needs and risks experienced by siblings of children with severe emotional disturbance and their caregivers. This discussion provides a springboard for policy recommendations to strengthen family support programming and enhance family-centered care, from modifying funding streams such that systems extend their reach beyond children with full-blown, diagnosable problems (those meeting standards of “medical necessity”), to supporting prevention and early intervention initiatives that address families as targets for intervention. Recommendations include ensuring that communities with SOC funding address the needs of families; broadening Medic-aid rules and definitions; expanding the range of reimbursable activities and services; and increasing funding for evaluating family-centered care models and family support programming.

Keywords

Family-centered services; Policy; Siblings; Systems of care

Estimates suggest that 4 to 7.5 million youth suffer from a major mental disorder that results in significant functional impairment, but only 20–25% receive needed mental health services (Burns et al. 1995; Friedman et al. 1999; US Department of Health and Human Services 1999). Ineffective, inadequate, or inappropriate treatment for youth with mental health issues relates to serious negative consequences, including school drop out and involvement with child welfare and juvenile justice systems (Institute of Medicine 2005). In addition, data suggest that, among those over 5 years of age, four of the ten leading disabilities are mental health disorders (Bazelon Center for Mental Health Law 2007).

In response to these challenges, recent decades have seen an increase in funding for children's mental health needs. One prime emphasis at the federal level has been on family-centered and family-focused approaches to care, such as the System of Care (SOC) philosophy (Cook and Kilmer 2004; Hernandez 2003; Holden and Brannan 2002; Holden et al. 2003; Huang et al. 2005; Pumariega and Winters 2003; Stroul and Friedman 1986) and its primary practice model, the wraparound approach (e.g., Burns and Goldman 1999; VanDenBerg and Grealish 1996). As a case in point, extensive federal funds (\$1.06 billion as of 2006) have been allocated to establish SOC for children with severe emotional disturbance (SED) and their families, most recently via the Comprehensive Community Mental Health Services for Children and Their Families Program, established in 1994 and administered by the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA). Children targeted in these programs have *DSM-IV* diagnoses, significant functional impairment, involvement with multiple agencies (e.g., mental health, social services, juvenile justice), and risk of out-of-home placement. Recently, the Children's Bureau (Child Welfare Information Gateway 2008a, b) has funded an initiative to implement the SOC philosophy within child welfare systems in multiple communities.

In the SOC philosophy and the wraparound approach, services and supports are purported to address the needs of the whole family, *not* just the individual child identified as the "client". This approach is based on the premise that supporting families and meeting families' needs can maximize the gains for children. However, despite the resources allocated to the development and implementation of systems, services, and supports that are family-centered and family-focused, there is a disconnect between the values and principles articulated as their central tenets and what occurs in actual practice. In fact, the extant data have significant policy implications for national SOC initiatives, suggesting the need to ensure that resources are dedicated to support not only "target" children with diagnoses, but the other children and caregivers in the families.

This paper (a) provides brief background on SOC and wraparound, the primary practice element of SOC; (b) highlights issues of fidelity and discrepancies between values and practice in the implementation of family-centered services, a core component of the SOC philosophy and the wraparound model; (c) draws on data to show the need for family-centered practice and family support programming, based on prior research and new findings that highlight the needs of siblings and caregivers of youth with SED; and (d) provides the rationale for family-centered care. This discussion underscores the clear need for systems, providers, and policies to better support families of children with SED and provides the basis for a series of policy recommendations that could lead to improved family-centered care and support.

Brief Background on Systems of Care and Wraparound

In light of the large-scale national initiatives that have funded the establishment of SOC and the decision by many states to "roll out" SOC principles as the primary guide to care for children with mental health problems and their families, this paper emphasizes work conducted in the context of these systems. Systems of care were defined initially as, "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families" (Stroul and Friedman 1986, p. xx). While that definition has evolved somewhat over time to underscore the dynamic and adaptive nature of the system, the contexts in which services are provided, the availability of services across administrative and funding jurisdictions, and the multiple network components in a SOC (see, e.g., Hodges et al. 2006, 2010), the SOC philosophy is,

at its core, grounded in the notion that a diverse array of services and supports from multiple agencies and disciplines must work collaboratively with community-based informal supports to meet the needs of children with SED and their families (Stroul and Friedman 1986). Family-focused, family-centered care—with the needs of the child and family dictating the services and supports provided—constitutes a key tenet of SOC (e.g., Huang et al. 2005; Stroul and Friedman 1986), and the wraparound approach is the practice model central to the implementation of SOC and consistent with SOC values and principles (Burchard et al. 2002; Burns and Goldman 1999; Goldman 1999; VanDenBerg and Grealish 1996). Conceptualizations have also emphasized that families should function as the primary decision-makers and should be recognized as equal, full partners in the planning of services for their child and family (e.g., Stroul and Friedman 1986). Although more recent definitions state that SOC should be “family driven” (e.g., SAMHSA, n.d.-a; n.d.-b), this language continues to emphasize that the “needs of the child and the family” are to dictate “the types and mix of services provided” (Technical Assistance Partnership for Child and Family Mental Health, n.d.).

A central element of the wraparound model is the Child and Family Team (CFT), composed of family members, professionals from community agencies, and informal supports, people important to the family who are not paid for their involvement (e.g., friends, neighbors, coaches). The team’s goal is to develop a plan tailored uniquely to the child and family, including not only their needs but also their strengths (Burns and Goldman 1999; Handron et al. 1998; Kendziora et al. 2001; VanDenBerg and Grealish 1996). In principle, within family-centered systems, family members are full partners in defining needs and making decisions about the plan of care which, in turn, matches the family’s needs and circumstances (Cook and Kilmer 2004; Tolan and Dodge 2005). In addition, a critical component of SOC and wraparound is to help families engage their broader communities and connect with informal or natural community supports, not just professionals (VanDenBerg and Grealish 1996; Cook and Kilmer 2010). In fact, some have called for family-centered systems that emphasize developing or enhancing families’ capacities to build networks of resources, with providers and other professionals taking on a more supporting role in helping the family improve its quality of life (Dunst et al. 1991). Such work can empower families meaningfully as they take steps to connect with supports in the community and are involved in developing and implementing action steps to improve their situation. One recent study supports the importance of family empowerment as an important change mechanism within SOC, seemingly mediating the relationship between family-centered care and positive changes in children’s problem behaviors (Graves and Shelton 2007). Overall, family-focused, family-centered approaches are believed to help systems and, in turn, teams take into account other aspects of the child and family’s ecological context that may influence their functioning (Cook and Kilmer 2010; Tolan and Dodge 2005).

Research examining the impact of SOC (see Cook and Kilmer 2004 for a review; see also Graves 2005; Stephens et al. 2004; Walrath et al. 2006) and the wraparound practice approach (e.g., Bruns et al. 2005b, 2007; Rast et al. 2005) on children and families has yielded mixed results. For instance, when children receiving services via SOC were compared with similar children in a matched community provided with “standard” services, SOC children had fewer juvenile justice charges, fewer suspensions, less need for special education, and better prosocial peer affiliation over a 24-month period (Holden et al. 2003). However, in some studies investigating the impact of SOC, youth who enrolled in a SOC but received no formal treatment showed greater gains than those who did receive formal services (e.g., Bickman et al. 1999). Such findings have raised questions about the nature and effectiveness of the treatments provided (e.g., psychotherapy); the types, quality, and utilization of supportive services (e.g., family support); and the social and community

factors in SOC sites that would lead to improvements in the absence of treatment (see Cook and Kilmer 2004). Taken in sum, the extant findings suggest that children and youth served via SOC evidence modest improvements in functioning, though it is not yet clear which components of the model actively contribute to child and family outcomes (see, e.g., Cook and Kilmer 2004).

Implementing Family-Centered Services: Issues of Fidelity

Beyond the concerns about the effectiveness of the treatment approaches employed, multiple studies have also raised serious questions about the implementation of the SOC philosophy (i.e., Do the practices and processes reflect the values of “system of care”? Are they consistent with the philosophy?) (e.g., Bickman et al. 1996, 1997, 1999). Questions about the degree to which wraparound practice and other key SOC elements (e.g., family-focused, family-centered care) are actually implemented in SOC are of particular concern. Although the notion of family-centered approaches may have broad conceptual support (Briggs 1996; Dunst et al. 1994; Friedman 1994), a developing literature evaluating the implementation of SOC indicates that fidelity to the values of the philosophy and the tenets of key practice models such as wraparound varies tremendously across multiple dimensions, and that sites are a long way from engaging in practices that align consistently with the SOC philosophy and wraparound practice approach (e.g., Cook et al. 2007b; Walker and Schutte 2005). In fact, researchers examining the practices and processes of CFTs have found that many teams fail to implement some of the components viewed as central to wraparound (e.g., Bruns et al. 2005a; Cook et al. 2007a, b; Davis and Dollard 2004; Epstein et al. 2003; Walker and Schutte 2005; Walker et al. 2003). This work has employed a variety of strategies, including the utilization of real time ratings made by trained observers (e.g., Davis and Dollard 2004; Epstein et al. 2003) interviews with case managers and families (e.g., Bruns et al. 2004), videotapes of CFTs (e.g., Walker et al. 2003) and scales completed by participants in CFTs.

A study of team members who rated CFT functioning (on the Participant Rating Form; Cook et al. 2007b) after 1,244 team meetings found that two of the items with the absolute lowest levels of endorsement were “We talked about the needs of everyone in the family;” and “The current plan addresses the needs of other family members.” Similarly, when trained observers rated over 100 team meetings, family strengths were only discussed in 23% of CFTs and few CFTs specified tasks for the family (33%) or other team members (19%) that promote family independence from services, such as building greater competence, broader social supports, or increased educational or employment status. Overall, growing evidence suggests that, despite a strong conceptual emphasis on family-centered systems, the broader needs of families are frequently neither discussed nor incorporated into plans of care. This lack of congruence between guiding principles and the reality of day-to-day practice has critical implications for the children and families served.

This disconnect between principles and practice is also rooted in policy that does not support directly ground-level, family-centered practice. That is, despite the fact that SOC funded through the CMHS are intended to provide assistance to “children with serious emotional disturbances *and their families*” (italics added, CMHS, 2005), most resources are dedicated to direct services for the youth with SED (Cook and Kilmer 2004). At issue is the fact that SOC funded through the Comprehensive Community Mental Health Services for Children and Their Families Program are not required to assess (let alone demonstrate) fidelity of implementation, and there is no systematic reinforcement for doing so. Of particular salience, attending to the needs of the whole family is not required (or, frankly, supported financially). In fact, although service systems provide some services to caregivers (e.g., consultation, support), they infrequently attend to the other family members who may be

experiencing difficulties but who do not fit the specific requirements for participation in the SOC (Cook and Kilmer 2004).

A prime factor contributing to this lack of attention is the fact that most current funding mechanisms, including most Medicaid plans, do not reimburse for services beyond those required to address the “medical necessity” of the “identified” clients; meeting the needs of the family and addressing the broader contexts in which they function (see, e.g., Cook and Kilmer 2010) are rarely viewed as necessary for funding and reimbursement. However, caregivers, advocates, and researchers have raised concern that the failure to address other family needs can impede the long-term recovery of the “identified” client and lead to potential negative consequences for siblings and others in the family (Kilmer et al. 2008; McCammon et al. 2002).

Needs Evidenced by Other Family Members

Few studies have examined the risks, resources, and adaptation of siblings of children with SED and their caregivers; however, existing research (Aguilar et al. 2001; Kilmer et al. 2008) has underscored the degree to which they, and the family system, may be impacted by the challenges experienced by the youth with diagnoses. Indeed, these siblings are believed to be at-risk not only because they are exposed to many of the same adversities as the identified child who is receiving services, but because they also have a brother or sister with SED and are influenced by that child’s impact on the family (e.g., such as contributing to decreased parental attention or increased family strain and distress) (Huang et al. 2005; Kilmer et al. 2008). Reinforcing that belief, many of their parents report a need for supports and/or mental health services for the siblings (and themselves). Nevertheless, with so much attention focused on the identified child, these other children may “slip through the cracks” of the system. Consistent with that notion, although significant research has focused on SOC and the functioning of system-identified youth (see Holden and Brannan 2002), their siblings and other family members have received scant attention in the literature as well as actual practice.

In the first systematic examination of siblings in the context of SOC, Kilmer et al. (2008) assessed siblings in the context of two SOC sites in North Carolina and found that they (a) had been exposed to extremely high levels of adversity and (b) evidenced substantial variability in behavioral and emotional strengths and social-emotional adjustment. Although many siblings exhibited significant strengths and positive adjustment, a substantial proportion displayed levels of competencies or problem behaviors suggestive of having an emotional or behavioral disorder. In fact, although the siblings as a group evidenced more positive scores on multiple indicators of strengths, resources, and adjustment than their system-identified brothers or sisters, a meaningful proportion of the siblings exhibited higher levels of maladjustment/problem behaviors (and fewer competencies) than many targets. More fine-grained analyses revealed that, even within families, a significant minority of siblings received scores equal to or worse than their own target brothers and sisters on the study’s key adjustment measures. As Kilmer and colleagues concluded, “While this pattern may be partly attributable to the benefits of treatments received by target SOC children, it reinforces the critical importance of adopting a plan for services that seeks to meet the needs of the *entire* family, including the siblings” (p. 7).

A just-completed study by the present authors sought to replicate and extend the work of Kilmer et al. (2008), using parent and teacher-completed indicators of adjustment and in-depth caregiver measures capturing developmental history, qualities of the family and caregiving environment, caregiver resources, and a range of other contextual variables. In this new study, families had at least one child with SED and at least one 5- to 10-year-old

sibling who did not have a history of receiving mental health services. The discussion here will focus on the stress exposure, strain, and adjustment of the siblings and their caregivers in this more geographically and socioeconomically diverse sample than that described by Kilmer et al. (2008).

Using a multidimensional Life Events Checklist (Kilmer et al. 1998), including several major, chronic stressors, caregivers indicated that siblings experienced an average of 9.65 stressors ($SD = 5.69$). Given that several studies of risk and resilience (e.g., Cowen et al. 1992; Wyman et al. 1999) have used exposure to ≥ 4 stressors on this same measure as a criterion for “highly stressed”, this finding indicates high stress exposure and underscores the level of risk experienced by the youngsters within participating families. Of the measure’s five factors, the factor with the most items, *Family Turmoil*, also captured the most endorsed items ($M = 4.79$, $SD = 2.65$), followed by *Poverty* ($M = 1.37$, $SD = 1.42$), *Family Illness/Injury* ($M = 1.30$, $SD = 1.27$), *Unsafe/Violent Neighborhood* ($M = .85$, $SD = 1.10$), and *Family Separation/Social Services* ($M = .57$, $SD = .86$). Several specific stressors were experienced by at least half of the siblings: family members have serious arguments (72%); child upset by family arguments (72%); serious emotional problems in family (63%); family member away from home a lot (58%); and our family had serious financial problems (52%).

These findings are consistent with what caregivers have reported in the longitudinal national evaluation of SOC. While that effort assesses a smaller number of specific risks, results have consistently indicated that youth and families enrolled in SOC are exposed to substantial adversity. For example, in a sample of 1,238 families participating in SOC initiatives across 28 sites, 71.0% of youth had a biological parent with major depression; 63.0% had a biological family member with a drug or alcohol problem; 48.3% had been exposed to domestic violence; 36.8% had lived with someone who had been convicted of a crime; 23.2% had been physically abused; and 15.5% had been sexually abused (US Department of Health and Human Services 2008). Notably, many of these stressful life events and circumstances reflect adversities that affect the entire family system and its members, not just the system-identified child.

In the new sibling study, direct comparisons between siblings and “target” children with SED demonstrate that, as a group, siblings evidence more strengths and resources, less symptomatology, and, overall, more positive adjustment than their brothers and sisters who have already been identified as having SED. These substantial group differences in adjustment are not unexpected; however, they do not capture fully the proportion of siblings exhibiting difficulties. Consistent with the findings reported by Kilmer et al. (2008), there is considerable variability in sibling adjustment, with some seemingly doing quite well, and a substantial percentage of siblings evidencing difficulties similar to those experienced by children identified with SED and receiving services. For example, on the Behavioral and Emotional Rating Scale (BERS-2; Epstein 2004), which yields Strength Quotients and standardized subscale scores that can be classified into one of seven levels (ranging from very poor to very superior), 40.4% of siblings had Strength Quotients indicating above average to very superior levels of personal strengths and very low probabilities of having an emotional or behavioral disorder, and 27.2% had Strength Quotients in below average to poor categories, reflecting borderline or lower personal strength levels and high probabilities of having an emotional or behavioral disorder (Epstein 2004). In the normative sample, roughly 23% obtained scores in each of these ranges (Epstein 2004); this is notable because these siblings had been judged to not meet criteria for SED nor require mental health services, yet they evidenced similar probabilities of disorder to a diverse sample of youngsters, including some with diagnoses. Using Conners’ Parent Rating Scales-Revised (CPRS-R: short version) norms, a notable percentage of siblings evidenced difficulties – i.e.,

roughly 19% of siblings' Oppositional scores fell in the Moderately to Markedly Atypical range, indicating significant problems (Conners 2001), and 16% of siblings' ADHD Index scores fell in that range, compared to only 5% (or less) for the normative sample on these scales. These findings, from validated, norm-based measures, reinforce the importance of attending to the needs of siblings. Not surprisingly, in light of the diverse presentations in the sibling sample, caregivers endorsed a range of needs for these siblings, reporting a need for school-based services for the siblings (e.g., counseling/therapy, speech/ language therapy, tutoring and remedial reading work, special education services) as well as services outside of school (e.g., counseling/therapy, psychotropic medication).

Caregivers also report noteworthy levels of strain, challenge, and difficulty. As one case in point, on the Brief Symptom Inventory (BSI-18), 22% had BSI-Depression scores and 32.4% had BSI-General Severity Index scores above clinical cutoffs (Derogatis 2001). They also reported multiple service needs for themselves (e.g., counseling/ therapy, respite care, drug/alcohol counseling, parenting education and skills training) or their family (e.g., family therapy).

Thus, while limited research has focused on these siblings, on the basis of existing data, a notable proportion of siblings and caregivers of youth with SED appear to have significant mental health needs. Even more significantly, many of these siblings are not receiving needed mental health services or supports. Although many do not currently display diagnosable adjustment problems, the adversity experienced by these siblings and their families warrants discussion. Although children vary in their responses to adversity, exposure to multiple, chronic stressors can increase substantially the probability of maladjustment (Luthar and Cicchetti 2000). Nevertheless, many of the stressors experienced (e.g., poverty, neighborhood violence, parental unemployment) by these children and families are not traditionally addressed by "mental health" service systems, despite findings that addressing such factors as parental employment and family poverty can have a significant impact on the functioning of children with mental health problems (see, e.g., Costello et al. 2003).

Moreover, the recognizable levels of difficulty experienced by meaningful percentages of the children and caregivers imply that the system at-large should be attentive to their needs and potential vulnerability. The levels of self-reported maternal distress and depressive symptomatology bear particular mention, given that a substantial evidence base documents the risk of maternal depression and/or other internalizing concerns on child adaptation and functioning (e.g., Goodman and Gotlib 1999; Rishel et al. 2006), and research suggests that, as caregivers struggle with their own symptoms, they have difficulty meeting the challenges of caring for a child with significant mental health challenges (e.g., Swartz et al. 2008). In light of findings that improved maternal functioning may relate to improved child functioning (e.g., Swartz et al. 2008) and, more specifically, that reductions in maternal depression mediated improvements in children's externalizing and internalizing behavior (after accounting for the potential role of positive parenting; Shaw et al. 2009), planning teams would do well to assess and address maternal strain and mental health concerns.

While many of those with diagnosable disorder(s) can receive help through existing funding streams if they have adequate health insurance, it is clear that many family members of children with SED are likely to experience very high levels of stress and could benefit from preventive and/or supportive services focusing on the entire family. As the research examining siblings demonstrates, many youth who do not meet standards for SED may very well require services and supports, and proactive, early intervention could reduce the likelihood that those at risk subsequently require more extensive and expensive assistance (see Farmer and Farmer 2001).

The Rationale for a Focus on Families

There are multiple reasons why behavioral health systems should dedicate their finite resources to the families of youth with SED—including their siblings and caregivers—even though many children and youth with severe difficulties do not receive needed services. First, and most critically, supporting families is not only consistent with the SOC philosophy and the wraparound approach, but likely reflects the most appropriate and effective means of treating the youth with SED. In fact, a core basis for any policies impacting children, including those establishing SOC, is the understanding that youngsters exist in larger ecological contexts (Bronfenbrenner, 1979, 2005; Cook and Kilmer 2010; Farmer and Farmer 2001; US Department of Health and Human Services 1999), particularly the family system.

Indeed, the caregivers and siblings in a child's family system are among the most powerful and significant proximal influences on that youngster's development and adjustment. As multiple researchers have asserted (see, e.g., Cairns et al. 1993; Farmer and Farmer 2001), contextual variables can cluster together to exert, in combination, positive or negative influences on children and families and their adjustment trajectories (i.e., "correlated constraints"). In turn, intervention strategies must attend to, reorganize, change, bolster, or otherwise address the *full range* of relevant factors (and especially the most salient factors) across youngsters' developmental systems, otherwise their reach and impact will be limited (e.g., Farmer and Farmer 2001; Farmer et al. 1999). This implies that the family, not just the child, needs to be the subject of supportive interventions to maximize the benefit for the identified children with SED. Consistent with that notion, there is growing evidence that family support can positively impact children's social, emotional and cognitive development, as well as family empowerment and economic self-sufficiency (Layzer et al. 2001). Put simply: plans of care need to include steps to address the needs of *all* family members to maximize the treatment benefits for the identified child and, in addition, have a preventive impact on the other family members who are at significant risk for future problems (see Farmer and Farmer 2001; Tolan and Dodge 2005). Furthermore, because these families are already connected with and accessing services for the youth with SED, the system at-large has contact with those family members and can readily extend its reach and impact through preventive or early intervention efforts with people who are already familiar with the mental health system.

Recommendations for Policy

Children with SED and their families could benefit from multiple changes in policies that would orient mental health systems to support and strengthen *families* rather than focus more narrowly on the needs of the identified children. Providing adequate support for families will require leadership at the federal level to make tangible changes in the ways that support is provided, funded, and sustained for families of children with mental health problems. Although the emphasis on families in SOC is a necessary and critical early step, the need for change extends far beyond the ongoing efforts to support the development of local SOC.

Broad proclamations of policy alone, though, do not result in actions that have measurable impact. Although the federal SOC initiatives have great potential for expanding family-centered care, these programs, even with their substantial funding and broad national and local support, can have difficulties translating concepts into actions. Local implementation should focus more on how to deliver needed services and supports to the family (i.e., including caregivers and siblings), and a number of more specific steps are needed to help ensure that a family-focused conceptual model is translated into specific practices that truly

address the needs of families at a local level. Building upon the leadership already demonstrated by SAMHSA, the Comprehensive Community Mental Health Services for Children and Their Families Program could require that applicants specify mechanisms for ensuring that broader family needs are being met. Thus, applicants would have to articulate strategies for identifying the needs of the whole family (e.g., screening the sibling at the time of intake) and addressing the family in the plan of care (e.g., identifying the needs of the family as a whole as well as its members; building on family strengths in the plan) and communicate steps for how they would do so within the constraints of the mental health system and community in which they are functioning. This could also result in better targeted models for implementing SOC and understanding their impact.

More specific and macro-level changes, however, would be necessary for the sustainable implementation of a “family-focused” national policy. Since a large number of families served in the public mental health system and through federally-funded SOCS are eligible for Medicaid, it is important to ensure that Medicaid rules are consistent with this policy shift. In particular, it would be critical to: (1) shift how the “patient” is defined, from the individual child to the family, so that the broader family would be legitimately the target of the system’s attention and intervention; and (2) expand the terms and definitions of the Centers for Medicare and Medicaid Services such that they are not solely built around “medical” necessity, but focus on the broader health needs of the child and family. Systems should attend to the contexts of the youngsters being served (see Cook and Kilmer 2010, for a consideration of the importance of working from an ecological framework in SOCs) and take steps to address the needs of the whole family. It is certainly conceivable that the system might still require that a “target” child meets criteria for inclusion (i.e., SED) and that child’s status is the requirement for the family’s entry to the system; however, the family would be viewed as the “patient” and have access to a full complement of services, supports, and other resources.

To that end, as others have noted (e.g., Cook and Kilmer 2010; Tolan and Dodge 2005), it is necessary to change and expand the range of activities and services that are reimbursable. That is, funding mechanisms should support components of a plan of care that would not meet criteria for “medical” necessity and are not traditional mental health interventions but that are associated with family stability and child and family well-being. As a case in point, parental employment may not be viewed as within the domain of concern for mental health, since it is not viewed as necessary for treating a child’s mental health challenges; however, earning a livable wage surely is salient to family functioning and critical to the family’s ability to address the child’s needs (e.g., Cook and Kilmer 2010; Luthar 1999; see also Costello et al. 2003). Mental health service providers should be reimbursed for helping families of children with mental health problems develop the capacity to secure living wage employment and obtain quality housing in a safe neighborhood. While the mental health service provider would not be responsible for providing job training or obtaining housing, they could take an active role in helping the family work with other community resources and providers to obtain the support the family needs. In addition, communities could work to ensure that these families have priority in receiving other types of supports.

Although the above discussion implies an expansion of the range of services and supports that would be provided under “mental health” services, mental health workers (often case managers) may not be the most appropriate (or sole) providers of support for families. Peer-to-peer family support models, in which families who have been part of the “system” provide support to other families, can also provide this assistance (Layzer et al. 2001). However, despite the fact that CMHS-funded SOCs have encouraged communities to develop parent-run organizations that can provide such family-to-family support services (Friedman 1994; Illback 1997), these programs often struggle to sustain themselves, even

when developed in the contexts of SOC's, because most funding sources for addressing mental health needs do not fund family support programming. In fact, with some exception (13 states permit certified peer support workers; e.g., Keele-Lien et al. 2009), these services are generally ineligible for reimbursement, because peer-to-peer family support providers often do not meet educational requirements for service providers. An expansion of those types and sources of support should be considered, serving to increase the amount of support that is available to families.

As the documented issues in implementation fidelity to the values of the SOC philosophy and the wraparound model would suggest (e.g., Walker and Schutte 2005), the need for ongoing, rigorous evaluation is critical. The proposed changes in service delivery and supports to address the needs of families in which a child has mental health difficulties would certainly warrant the devotion of focused research funding to evaluate the impact of these changes. It is crucial to build in mechanisms for understanding which types of supports and providers can have the greatest impact. However, the findings reported above highlight the need to change policy, including modification of funding mechanisms, to help put a "family" focus into action and better address the diverse needs of the whole family (Farmer and Farmer 2001; Kilmer et al. 2008; Tolan and Dodge 2005). Such changes would be consistent with current "family focused" service models and the Surgeon General's (US Department of Health and Human Services 1999) call for the development of services that transcend a traditional "focus on the 'identified client' to embrace the community, cultural, and family context" (p. 186).

Such steps are needed to move beyond rhetoric regarding service delivery models and strategies and ensure that the central tenets of family-oriented approaches are translated to actual practice, particularly when a broader approach integrating treatment, early intervention, prevention, and wellness promotion is warranted (e.g., Tolan and Dodge 2005). While the costs for the changes recommended here will be substantial, these steps are likely to be not only more humane, but also more efficacious and cost effective in the long run (see, e.g., Cowen 1994; Tolan and Dodge 2005).

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