

Child Welfare Issue Brief

Supporting Parents With Mental Health Needs in Systems of Care



Technical Assistance Partnership for Child and Family Mental Health
A partnership of the American Institutes for Research® and the National Federation of Families
for Children's Mental Health

About the Technical Assistance Partnership for Child and Family Mental Health

The Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) provides technical assistance to system of care communities that are currently funded to operate the Comprehensive Community Mental Health Services for Children and Their Families Program. The mission of the TA Partnership is “helping communities build systems of care to meet the mental health needs of children, youth, and families.”

This technical assistance center operates under contract from the Federal Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

The TA Partnership is a collaboration between two mission-driven organizations:

- The American Institutes for Research—committed to improving the lives of families and communities through the translation of research into best practice and policy
- The National Federation of Families for Children’s Mental Health—dedicated to effective family leadership and advocacy to improve the quality of life of children with mental health needs and their families

The TA Partnership includes family members and professionals with extensive practice experience employed by either the American Institutes for Research or the National Federation of Families for Children’s Mental Health. Through this partnership, we model the family-professional relationships that are essential to our work. For more information on the TA Partnership, visit the Web site at <http://www.tapartnership.org>.

About This Study

This study was completed on behalf of the Technical Assistance Partnership for Child and Family Mental Health with support through an interagency agreement between the Children’s Bureau, Administration for Children and Families, and the Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, both within the U.S. Department of Health and Human Services (HHS). The content of this report does not necessarily reflect the views or policies of HHS, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.

Suggested citation:

Friesen, B., Katz-Leavy, J., & Nicholson, J. (2011). *Supporting Parents With Mental Health Needs in Systems of Care*. Washington, DC: Technical Assistance Partnership for Child and Family Mental Health.

***Supporting Parents With Mental Health
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July 2011



Acknowledgments

Special thanks are extended to Kim Helfgott, who served as the AIR Project Coordinator and whose expertise and enthusiasm guided us throughout the course of this work. Thanks also go to Gary Blau, Chief, and Diane Sondheimer, Deputy Chief of the Child, Adolescent and Family Branch, Center for Mental Health Services Substance Abuse and Mental Health Services Administration, and to Cathy Overbagh, Program Specialist, Division of Research and Innovation, Children’s Bureau, Administration for Children, Youth and Families, for their support throughout the course of this study.

Finally, gratitude must be extended to the staff members, agency collaborators, and family partners at the six contributing program sites, who so generously gave their time and insights, and who share a passion for identifying (often through much trial and error), improving, and replicating practices to help families lead fulfilling lives.

Supporting Parents With Mental Health Needs in Systems of Care

Introduction

Children enrolled in community-based systems of care (SOCs) whose parents live with mental illness can face additional challenges to remaining in their homes with their families, in school, and out of trouble (Rosenblatt, 1993). Children whose parents have mental health needs are at greater risk of developing emotional and behavioral difficulties than children of parents who do not have mental health diagnoses (Beardslee et al., 1996; Nicholson, Cooper, Freed, & Isaacs, 2008; Riley et al., 2009; National Survey of Child and Adolescent Well-Being, 2005). Parents with mental health needs are at greater risk of repeated involvement with the child welfare system and ongoing family instability (Libby, Orton, Barth, & Burns, 2007); when their children are placed in out-of-home care, they face many barriers to reunification (Friesen, Nicholson, Kaplan, & Solomon, 2009; U.S. Department of Health and Human Services, 2004). While all parents who have children with serious mental health conditions can benefit from comprehensive, individualized support for their families, parents living with mental illnesses may need additional medical, mental health, and parenting support (Tebes, Kaufman, Adnopo, & Racusin, 2001; Friesen et al.; Nicholson & Deveney, 2009). Although addressing parents' mental illness is likely to improve mental health outcomes for their children (Weissman et al., 2006), several studies indicate that fewer than half of caregivers receive mental health treatment (Libby, Orton, Barth, & Burns; Staudt & Cherry, 2009).

SOCs must address both the needs of parents with mental illness and the needs of their children. Learning more about the challenges faced by SOC in this area, and the strategies they implement to overcome them, provides insights with implications for the broader field. This project was intended to learn more about efforts to assess parents' mental health needs, effectively engage and support them, and improve system coordination and access to services to inform service delivery and system reform, especially for those involved in both child welfare and mental health.

This report presents information gathered from a small sample of federally funded SOC communities between March and October 2010. Project directors, lead family contacts, clinical supervisors, family partners, and other staff, along with representatives of partner organizations, especially child welfare, generously shared information about their approaches to policies and practices designed to support whole families—children, youth, and parents or other caregivers.

Addressing the complex needs of families living with parental mental illnesses and the emotional and/or behavioral problems of their children requires a comprehensive, coordinated approach. An SOC is an organizational philosophy and framework that involves collaboration among agencies, families, and youth for the purpose of improving access and expanding the array of coordinated, community-based, culturally and linguistically competent services and supports for children and youth with serious emotional disturbance and their families (Stroul & Friedman, 1986).¹ As a requirement of the Comprehensive Community Mental Health Services for Children

¹ In 1992, Congress passed legislation creating the Comprehensive Community Mental Health Services for Children and Their Families Program, administered by the Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Service Administration, which has funded States and local communities to build SOC. At the core of this program is the goal of developing a comprehensive array of community-based services and supports guided by an SOC philosophy.

and Their Families Program, SOC grantees seek to improve the coordination of services provided by agencies and increase access to a full array of individualized services and supports to address the needs of children, youth, and families.

Exploration of 15 selected SOC communities revealed that some employ purposeful screening and assessment, engagement, and intervention strategies with adult family members, as well as their children. Some facilitate effective collaborations between child- and family-serving agencies and parent-run organizations, and promote innovations in policy and practice to address the parents' identified needs. This report shares some of the challenges, as well as lessons learned in addressing parents' mental health needs, engaging them in team planning and/or mental health services, providing and paying for appropriate services, and coordinating care across community partners.

Barriers to Reaching Out to Parents With Mental Illnesses

SOC communities identified many barriers to identifying and addressing parents' mental health needs. The stigma associated with mental illness and parents' unwillingness to disclose their related needs are critical barriers. Parents may be reluctant to acknowledge their mental health issues because they fear that providers' attitudes may be negative or judgmental. Further, appropriate services for parents with mental illnesses are often difficult to obtain because of eligibility requirements (e.g., for adult mental health services), waiting lists, lack of appropriate services, and a lack of funding for services.

Most SOCs do not systematically assess the mental health of parents of children enrolled in the SOC or use formal measures or tools as part of a more comprehensive intake and assessment process. Although all SOCs estimated the prevalence of mental illness among parents as high, some respondents indicated that parents were not asked about their own mental health or needs; if an adult family member wanted help, it was considered to be his or her responsibility to make requests in team planning meetings.

Comprehensive, "whole family" services, resources, and supports were generally not available in identified SOC communities. Specialized services and systems that support adults are separated from child and youth services, and each service is often targeted by specific agencies with differing expectations and funding requirements (e.g., child and adult mental health, substance abuse).

Overcoming Challenges in Implementing System of Care Values and Principles

The full participation of families and youth in service planning, development, evaluation, and sustainability of overall system transformation efforts is a core principle of SOC. However,

Barriers to accessing adult mental health services include the following:

- Parents don't meet eligibility requirements.
- Parents lack insurance.
- Appropriate services are not available.
- Services lack a "whole family" approach.
- The distance is too great (or parents lack transportation).
- Parents may give up when seeking services is too frustrating.

implementation of “family-driven” and “strengths-based” values and principles was considered unrealistic by some SOC partners, particularly when parents or caregivers had mental illnesses or substance use disorders. Some collaborating agency representatives expressed skepticism about including family partners or other parents in decisionmaking meetings (e.g., individualized team planning meetings, budget meetings, or policy councils). However, participation in meetings where strengths-based, empathetic, nonjudgmental responses were applied to all participants helped some partner agency representatives see the value of engaging parents.

As positive outcomes for children and families living with parental mental illnesses were achieved, collaborators from partner agencies were likely to be more receptive to implementing a family-friendly, strengths-based approach. A positive outcome was not always defined as family reunification; in some cases it meant an orderly, carefully planned and supported relinquishment of custody by parents with mental illness, who also participated in supporting their children through the adoption process.

One child welfare worker who began by being skeptical about family-driven services identified the following principles for addressing the needs of parents with mental illnesses:

- Think “out of the box.”
- Build trust.
- Build on parents’ strengths.
- Relinquish control.
- Understand that different types of parenting may be acceptable.
- Build in accountability.
- Access flexible funds.
- Employ family partners who connect with parents at a practical level.

Successful Approaches Identified by System of Care Communities

Across SOC communities, there are several approaches that have strengthened the capacity to support family members:

- A well-articulated, *guiding framework for practice* that orients staff and families to the purposes, goals, and outcomes of services was found to be extremely useful.
- *Family partners* were often effective in identifying, engaging, and supporting families in which a parent or other adult caregiver is living with mental illness.
- *Collaborative partnerships* between providers and family members and across agencies and systems promote appropriate care and support for parents or caregivers living with mental illnesses, including those who have child welfare involvement.

Guiding Frameworks for Practice

SOCs that were confident about their ability to problem-solve and successfully address challenges, including meeting the needs of parents with mental illness, all identified the importance of having a framework to guide their practice. Although all SOC are guided by a shared set of values and principles (Stroul & Friedman, 1996), some SOC have committed substantial resources (e.g., time, funding, and effort) to cross-training all system partners and to developing a shared set of values and principles, some of which are formalized in written agreements with strategies for implementation.

The focus, breadth, and comprehensiveness of the practice frameworks identified by SOCs varied. Several had implemented more than one of the frameworks described below. Practice frameworks helped providers do the following:

- Approach parents with mental health needs in positive, nonjudgmental, strengths-based ways (i.e., question their own possibly negative assumptions and stereotypes to recognize parents' strengths, respect their experiences, and value their contributions).
- Understand that parents are likely to set goals that are relevant to their families and prioritized according to their perceptions of need (e.g., my child needs an after-school program, which is more important to me than getting myself a therapist; my child's feet have grown, so I'm going to spend my money on shoes rather than my medication).
- Recognize that while parents' goals may not be the same as the professionals', they must be respected because parents' engagement is critical to progress for all family members.

Wraparound has been adopted by several SOCs as a guiding framework for practice (Bruns et al., 2004; Walker & Bruns, 2008; Walker et al., 2004; Penn & Osher, 2007). As described by the National Wraparound Initiative, Wraparound is a planning process that results in the identification and implementation of unique community services and natural supports that are individualized for the child and family to achieve positive outcomes (Bruns et al.). Services are "wrapped around" the child and family in their natural environment. Cross-training for child welfare and mental health systems in Wraparound processes is critical for building relationships, identifying shared goals among system partners, and securing buy-in for consistent implementation of wraparound values and processes. Implementation of "high fidelity" Wraparound implies that systemic, ongoing quality assurance evaluation is conducted to ensure that the process model is being implemented as intended.

Trauma-informed SOC ensures that every part of the organization, staff, and service delivery system is assessed and potentially modified to reflect an understanding of how trauma affects the lives of individuals seeking services. Providers and community organizations transform the ways services are delivered to children and families, taking participants' lived experiences of trauma into consideration and taking care not to retraumatize participants in the routine course of service delivery. In THRIVE, a trauma-informed SOC in Maine, a training program and toolkit have been adapted from the National Child Traumatic Stress Network, and training is provided to all child welfare caseworkers and supervisors, foster parents, and SOC family partners. The trauma-informed approach is very valuable for SOCs because it provides a way to look at parents' and children's mental health issues through the lens of trauma with less "shame and blame."

Motivational interviewing is a person-centered, directive method for facilitating engagement and commitment to change by helping people explore and work through ambivalence (Miller & Rollnick, 2002). Originally developed in the field of addictions, motivational interviewing employs a process that empathetically acknowledges people's fears, concerns, and perceived barriers; supports their empowerment and self-efficacy; is nonjudgmental about "resistance"; and works with people to recognize gaps between their current situations and where they would like to be. In the Alamance County SOC, in North Carolina, staff members are trained,

supervised, and supported in motivational interviewing to enhance engagement with parents and to focus on goals they identify. This approach may be particularly useful when working with parents with mental illness who want to regain custody or work on plans to have their children return home.

Developmental Model of Family Support was developed by Fran Goldberg (Project ABC, Los Angeles), based on Prochaska, Norcross, and DiClemente's (1994) theoretical framework for change, which also is reflected in motivational interviewing. This approach begins with the provider listening to parents' descriptions of their struggles, their aspirations, and their assessment of their own situation, and then working in a respectful and responsive way to develop a plan for change.

Family Partners

Family partners play a variety of roles, ranging from engagement, support, education, and advocacy at the direct-service level, to leadership of parent organizations, management of some functions of the SOC, and participation in the development and implementation of new policies at the system level. Although family-run organizations that recruit and support SOC parent partners do not specifically focus on parents' mental health, they consistently report that parents with mental health needs are more likely to open up to a peer partner than to trust and engage with most professionals. This is particularly noted with regard to the child welfare system, where parents often fear that revealing a mental illness will result in their losing custody of their children.

Family partners in all the SOCs operate from a philosophy of "whatever it takes." They are able to relate to parents on a personal level, and they often spend more time with families than care coordinators did. They provide assistance in a variety of ways, including helping parents enroll their children in the SOC, assisting families in finding affordable housing, helping parents access flexible funding, teaching parents budgeting skills, supporting them in finding employment, teaching them how to advocate for themselves and their children, and helping them access mental health treatment. The focus is universally on supporting parents and caregivers to become empowered to advocate for themselves.

As a trauma-informed SOC, THRIVE assumes that all families coming for service are likely to have been traumatized in some way by previous life experiences. THRIVE staff and *family partners* alike are comfortable recognizing and addressing signs of trauma. Family partners function as peer specialists on the wraparound team, not as case managers, and they are the family's first contact with the SOC. Training in trauma-informed services helps family partners think differently about how they engage family members, reminding them to ask parents how they are doing and how they can attend to their own mental health needs. Trauma training also helps family partners look at their *own* issues in order to be better parents, and to model this reflective stance for new families entering the SOC. To institutionalize this approach, THRIVE is creating policies and procedures for providing trauma-informed peer-to-peer support and strategies for effectively engaging parents.

Despite nearly universal agreement that *family partners* are crucial in identifying, engaging, and supporting parents living with mental illnesses, support for their role may be completely dependent on Federal grant funds and thus lack a secure and permanent funding base. Several strategies, now emerging, may help sustain the role of *family partners* in supporting children, youth, and families in systems of care. One such strategy involves the creation of certification

programs that establish standards for services provided by family partners and that may lead, ultimately, to making family partners eligible Medicaid providers under several different billing categories. An example of a strategy designed to promote high-quality, sustainable family partners is the Parent Support Providers Certification initiative of the National Federation of Families for Children’s Mental Health (2011).

Collaborative Partnerships

Collaborative partnerships at every level—practice, program, and system—are essential to promoting a whole-family approach when parents are living with mental illnesses and families may have child welfare involvement. Barriers to relevant services and supports for these parents are best addressed through collaborative approaches and partnership building across human service systems. Interagency collaborations (e.g., advisory councils, learning collaboratives) that include members from key agencies, as well as family members, provide the context and strategies for identifying and dealing with gaps in services and among organizations.

Parents are not often asked directly about their own mental health when their children are enrolled in SOCs, but these issues may come to the attention of providers or family partners as they get to know families better over time. Parents may only acknowledge their own needs after relationships have developed. Key informants often talked about parents’ fears of custody loss if their mental illness become known to child welfare or other providers. Parents’ fears may undermine information sharing that is essential to collaboration between parents and providers, and among providers. Some SOCs have developed informed consent procedures for parents, to facilitate information sharing among providers.

Adult mental health needs may be unmet, in part, because parents do not ask for help. SOCs differ in whether they take on the responsibility of identifying and discussing parents’ mental health needs or wait for parents to raise the issue. However, as one family member has explained, “How will they know what we need if we don’t open our mouths . . . and admit there might be something wrong?” According to this parent, “I have to fix myself to help my kid.” Even though their children are involved in an SOC, adults may not be able to access and pay for mental health services themselves, may not have insurance, or may not meet eligibility requirements for State-funded services. There is recognition that links between parents and adult service providers need to be facilitated to assess parents’ mental health needs accurately and prescribe treatments and/or medications if necessary. However, in some cases parents may give up seeking help when their problems are complex and obtaining services is too frustrating. Further, even if services are accessed through the SOC, parents may not be able to continue to receive these services and supports once their children graduate from the SOC.

In the best-case scenarios, child and family teams in SOCs collaborate across child and adult service providers and community agencies, with buy-in from and access to essential services and supports for all family members. Collaboration may be facilitated by geographic proximity, but it is also enhanced by a shared understanding of the challenges faced by parents with mental illness, knowledge about effective intervention resources and approaches, and a commitment to identifying strengths and achieving goals identified by family members. Suggestions for addressing parental mental health needs include the following:

- ***Co-location:*** Families’ needs may be better met when child and adult mental health providers, or mental health and child welfare workers, are located under one roof or organizational structure. This promotes shared responsibility and facilitates personal

contact, relationship building, and collaboration among providers. Engagement with families also is facilitated when family partners are co-located in child welfare agencies and/or in child and adult mental health agencies.

We acknowledge, as a community, what the barriers are. Everyone comes to the table and looks at them. This is the real strength . . . all are willing to come to the table and “take the heat.” They all believe in this process and are trying to work it out together. . . . They look out for each other, to take care of children and youth.

- **Cross-training:** Some SOC's have committed substantial resources (e.g., time, funding, and effort) to cross-training all system partners and to developing a shared set of values and principles. Providers within an SOC often are trained in strategies for setting aside their own assumptions and judgments about parents with mental health needs. They benefit from training in practice models that individualize services and recognize the strengths and multiple needs of all family members, including parenting and mental health issues, to build capacity and strengthen the family.

We identified a common problem we all wanted to fix. . . . We saw each other as partners in developing solutions. We knew the problems were there.

- **Identification of strengths and goals:** Providers in SOC's work in partnership with parents and family members to identify strengths and develop goals. When parents with mental illnesses choose goals other than those professionals might suggest (e.g., focusing on meeting basic family needs rather than committing time and energy to individual mental health treatment), they may be labeled as “resistant” or “noncompliant.” A key informant suggested that when families are an active part of the team, the term “noncompliant” doesn't make sense. Ask, “Whose goals?” she recommends. Providers from various systems, including child welfare, with a focus on deficits or diagnosis can be perceived as parent blaming, which may present a barrier to collaboration.

We had to acknowledge our differences of opinion, look for ways to work together, and address the problems, rather than be adversarial.

Relationship building that provides the foundation for collaboration has the added value of paving the way for changing procedures and practices across agencies and systems, including realigning funding for services. In the Impact SOC, in Ingham County, Michigan, the child welfare and juvenile justice agencies pay a case rate based on a set of bundled services. Approximately \$13,000 covers family guidance, which includes intensive in-home services, wraparound service planning, and family advocacy for 1 year, although many families use services for fewer than 12 months. Fifty percent of local expenditures are reimbursed by the State through the Child Care Fund. Medicaid waivers provide medical assistance outside the capitation and allow local money (59 percent reimbursed by the State) to stretch farther.

Effective strategies for collaboration require not only shared knowledge among providers about the needs of families living with mental illness but a mutual understanding of organizational mandates and priorities that promote or preclude collaboration on behalf of families. Collaborative partnerships are built through a process of reflecting on shared problems, building trust, learning across sectors, and committing to action steps to achieve mutually beneficial solutions. Some SOC communities bring challenging scenarios to the group and engage in open discussion and problem solving.

An active collaborative structure is most effective when leadership expects and models authentic problem solving and solution-focused interactions among administrators, providers, and family members. The modeling of collaboration by agency leadership creates change at all levels of the organization, including reduced staff stress and improved relationships with families and children. This process gradually results in paradigm shift and philosophy change more consistent with the principles guiding SOCs.

Summary

The selected SOCs offer some insights and strategies for addressing the needs of families when a parent has a mental illness and the family is involved with the child welfare system. Commitment to a practice framework consistent with the values and principles of SOCs helps organizations across sectors develop a shared understanding of an approach and goals for supporting families living with parental mental illness. Such a framework serves to create an environment in which families are respected and less likely to feel blamed. The framework guides problem solving among all service sector providers and families, helping them to identify and address needs more effectively.

Family partners play an essential role in engaging parents in SOCs and identifying and meeting their needs. This role is equally, if not more, important when a parent also is faced with his or her own mental health condition and is involved with the child welfare system. Child welfare partners in many of the SOCs acknowledge how working with family partners has helped change their attitudes and approaches toward families living with mental illnesses. Sustainability is a critical issue that is currently being addressed through efforts to develop certification and reimbursement programs. Other funding strategies must be identified.

Strengthening existing partnerships, expanding collaboration, and realigning funding for services with new partners and service providers will be necessary to strengthen the whole family—children receiving SOC services, their siblings, and their parents (including those living with mental illness). Strengthening collaboration among the adult mental health, substance abuse, and child welfare service systems, and forging new connections with supported employment, housing assistance, and the Temporary Assistance for Needy Families (TANF) program will improve the ability of SOCs to promote better mental health and well-being for the children, youth, and families that they serve.

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Appendix A: System of Care Communities Participating in Phase I of Study

1. Alamance County DSS, Burlington, NC
2. Chautaugua County, Mayville, NY
3. Family Voices Network, Erie County, NY
4. Impact, Ingham County, MI
5. MD Department of Health and Mental Hygiene, Baltimore, MD
6. Nassau County, Amityville, NY
7. NE Iowa Community Circle of Care, Dubuque, IA
8. Orange County System of Care, Montgomery, NY
9. Project ABC, Los Angeles, CA
10. STARS Network, Monticello, MN
11. THRIVE Initiative, Lewiston, ME
12. Transforming Children’s Mental Health Through Partnership, Placer County, CA
13. WIN-GA, Lafayette, GA
14. Wraparound Oregon—Early Childhood, Multnomah County, OR
15. Youth and Their Families, Wilmington, DE

Appendix B: System of Care Communities Participating in Phase II of Study

1. Alamance County DSS, Burlington, NC
2. Impact, Ingham County, MI
3. Project ABC, Los Angeles, CA
4. THRIVE Initiative, Lewiston, ME
5. WIN-GA, Lafayette, GA
6. Wraparound Oregon—Early Childhood, Multnomah County, OR

Appendix C: Author Biographies

Barbara Friesen, Ph.D., Research Professor, Regional Research Institute, Portland State University

Barbara Friesen, Ph.D., served as the Director of the Research and Training Center on Family Support and Children’s Mental Health from 1986 to 2009, and recently has been the Co-Principal Investigator of Practice-Based Evidence: Building Effectiveness From the Ground Up project and of a current project focusing on transition-age Native American youth. She has also provided project leadership on a number of other federally and locally funded research projects and evaluations. Author of more than 70 chapters, articles, and reports in the field of children’s mental health, Dr. Friesen serves on the editorial boards of major journals in the fields of social work and children’s mental health. She has authored publications on a number of mental health topics, including residential treatment, professional training, family support, resilience and recovery, and practice-based evidence. Dr. Friesen contributed to the U.S. Surgeon General’s Report on Children’s Mental Health and served on the committee preparing the children’s mental health background report for the President’s New Freedom Commission on Mental Health. Well grounded in practice experience, she has worked in both clinical and administrative positions in varied mental health settings, including state institutions and adults’ and children’s psychiatric day treatment programs. Dr. Friesen has received recognition from the National Alliance for Mental Illness and the National Federation of Families for Children’s Mental Health, as well as several local and State family organizations, and has been recognized within Portland State University for scholarship and service, including a 2009 Civic Engagement Award for excellence in community-based research.

Judith Katz-Leavy, Consultant, former Senior Policy Advisor for Children’s Mental Health, Center for Mental Health Services

Judith Katz-Leavy is a consultant in the field of child and family mental health. She served for more than 30 years in high-level positions related to children’s mental health services and systems of care in the National Institute of Mental Health and the Substance Abuse and Mental Health Administration. She was the cofounder of CASSP (the Child and Adolescent Service System Program), which provided the blueprint for systems of care. During 1992 and 1993, she served on the President’s Health Care Reform Task Force and in 1999 as section editor for *Mental Health: A Report of the Surgeon General*, Chapter 3: “Children and Mental Health.” Since retiring from Federal service, Ms. Katz-Leavy has served as a consultant to the National cross-site evaluation of SAMHSA’s Comprehensive Mental Health Services for Children with Serious Emotional Disturbances and their Families Program. She has also completed several studies including a review for the Department of Labor of promising employment practices for transitioning youth with mental health needs.

Joanne Nicholson, Ph.D., Professor of Psychiatry and Family Medicine, University of Massachusetts Medical School

Joanne Nicholson, Ph.D., is a clinical and research psychologist, and Professor of Psychiatry at the University of Massachusetts Medical School (UMMS). She directs the Child and Family Research Core of the UMMS Center for Mental Health Services Research. Dr. Nicholson has established an active program of research on parents with mental illnesses and their families, in partnership with people in recovery. Her team is developing education and skills-training materials for parents, integrating the current knowledge on parents with mental illnesses, and evaluating

interventions for families, including the pilot Family Options intervention. She is the lead author of *Parenting Well When You're Depressed*. Dr. Nicholson's research interests also include the study of collaborations, knowledge exchange, and the impact of Web-based interventions. Dr. Nicholson has received funding from the National Institute on Disability and Rehabilitation Research, the Substance Abuse and Mental Health Services Administration, the National Alliance for Mental Illness Research Institute, private foundations, and industry sources. In 2006, Dr. Nicholson received the Armin Loeb Award from the U.S. Psychiatric Rehabilitation Association for her significant career contribution to research in psychiatric rehabilitation. She has been a William T. Grant Foundation Distinguished Fellow and a NIDRR Switzer Distinguished Research Fellow. She is the 2010 recipient of the UMMS Women's Faculty Committee Outstanding Community Service Award, and the 2011 recipient of the Katharine F. Erskine Award for Women in Medicine and Science.

